

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1640
10223
Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges
City or town Clinton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
Woodyard Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1 Box 196
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Edgar Lee Allen

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Bessie Pearl Allen
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 12, 1873
8. AGE: Years 74 Months 0 Days 0 If less than one day
hrs. min.

9. Birthplace Camp Springs, Md
(Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business Rail road
12. Name Edmond Allen
13. Birthplace Maryland
14. Maiden name Unknown
15. Birthplace Maryland

16. Informant Edgar Lee Allen Jr
Address Clinton Md
17. Burial Date thereof Nov 25-47
(Burial, cremation, or removal? Which?) (month) (day) (year)
Cemetery or crematory Edgar Hill Cemetery
Location Suitland Maryland
18. Funeral director Arthur S. ...
Address 2007-7th St. S.E.
19. Nov. 22nd 19 47 Theresa J. Beese
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1947 at 8:50 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19... 19...
and that I last saw him... alive on... 19...
Immediate cause of death Hemorrhage and shock
DUE TO gun shot wound of head
DUE TO
Other conditions
(Include pregnancy within 8 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide suicide Date of 11-22-47
Where did injury occur? Clinton P. G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) In a field
Means of injury shot self with revolver
helped medical examiner
23. SIGNATURE James D. ... M.D. or other
Address Forestville Md Date signed 11-22-47

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 28 1947

REAUVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10230

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince Geo. Co.

City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr. Geo. Co.

City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 - Que Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Wade Althaus

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 8 - 1939

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8

2

5

hrs.

min.

9. Birthplace

Alma, Mich
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name

Richard S. Althaus

13. Birthplace

Ashtabula, Ohio

14. Maiden name

Corliss Harnack

15. Birthplace

Greenbelt, Mich

16. Informant

Richard S. Althaus

Address

6 - Que Ridge Rd. Greenbelt

17. Burial

Burial

Date thereof

11-15-47

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Wash. National

Location

Suitland, MD

18. Funeral director

W. W. C. Hanks &

Address

Princeton, MD

19. Date rec'd by registrar

Nov 14

47

James Seery

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 19 47 at 4:45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/9/47 18 11/13 19 47

and that I last saw him alive on 11/12/47

Immediate cause of death Respiratory failure

DURATION

Due to

Pulmonary edema

Due to

Broncho pneumonia

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William H. Essie

M. D. or other

Address 16 B. Parkway Rd. Date signed 11/13/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 17 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10231

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George Md.
 City or town Pineville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 hr. & 15 minutes
 Hospital, institution, or street address where death occurred:
4408 Queensbury Rd.
 How long in hospital or institution? one hour & fifteen minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town not Pineville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4512 - 30th St., Pineville, Md.
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Elma Christina Anderson

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married Widowed
 6. (b) Name of husband or wife Husband: Gustav Anderson
 6. (c) If alive, give age Deceased years
 7. Birth date of deceased (mo., day, yr.) July 5, 1863
 8. AGE: Years 84 Months 4 Days 9 If less than one day
— hrs. — min.

9. Birthplace Stockholm Sweden
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

FATHER 12. Name not known
 13. Birthplace Sweden
 MOTHER 14. Maiden name not known
 15. Birthplace Sweden

16. Informant Mrs. Agnes (Charles) Conner
 Address 187 - 35th St. NE Apt 3 -
Burial Date thereof Nov 18 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Bedar Hill Cemetery
Swissland Maryland
 Location

18. Funeral director The S. W. Ginn Co.
 Address 2901-14th St. N.W. Wash. D.C.

19. Nov 14 1947 James Seng
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1947 at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11-13 1947, to 11-14 1947
 and that I last saw h. er alive on 11-14 1947

Immediate cause of death Congestive
Thrombosis

DURATION

2 days

Due to Arteriosclerotic 10 years
Heart disease or more
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dayton O Watkins MD M. D. or other

Address 5306 Annapolis Rd
Hyattsville, Md. Date signed 11-14-47

Dr James Boyd - County Medical
Examiner notified

L W Perkins



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10232

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Pro Gys Co
City or town Kirardale Ind
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Ind County Pro Gys Co
City or town Kirardale Ind
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6308 45 place
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Eleanor Harless Ballinger 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife ordway G. Ballinger
7. Birth date of deceased (mo., day, yr.) Jan 19, 1893. 6. (c) If alive, give age 54 years
8. AGE: Years 54 Months 9 Days 16 It less than one day hrs. min.

9. Birthplace va (Town, county, and state)
10. Usual occupation Director of nursery school
11. Industry or business own business

12. Name James R. Harless
13. Birthplace va

14. Maiden name Leona Palmer
15. Birthplace va

16. Informant W. Richard Ballinger
Address Hyattsville Ind.

17. Date thereof Nov 7, 1947
(Month, day, year)
Cemetery or crematory Floyd

Location Virginia
18. Funeral director F Gascha sons
Address Hyattsville Ind.

19. Date rec'd by registrar Nov 4, 1947
Registrar Mrs Jas Severes

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-47 19. 5:15 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 19. 42 to 11-5- 19. 47
and that I last saw h. ev alive on 11-4- 19. 47

Immediate cause of death Carcinoma of left breast
DURATION 5 mo.

Due to metastasis to
Due to left cerebrium 8 wks.

Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of left Breast
Date of op. July 13, 1947

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)

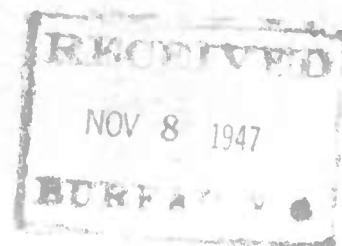
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A Jife Heath Md
M. D. or other
Address 1833 - Monroe NE Date signed 11/5/47
Wash 18, DC

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1630

10234

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Landover
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
In woods

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Edmonston
(If outside city or town limits, write RURAL and give nearest town)Street No. 4703 - Langford Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Howard Henry Beall

3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Catherine Beall

7. Birth date of deceased (mo., day, yr.)

Nov 15, 1916

6.(c) If alive, give age 31 years

8. AGE:

Years

Months

Days

If less than one day

31

hrs.

min.

9. Birthplace

Ritchie, Md.
(Town, county, and state)

10. Usual occupation

Wichster

11. Industry or business

FATHER

12. Name

Clayton Beall

13. Birthplace

Maryland

MOTHER

14. Maiden name

Agnes Simpson

15. Birthplace

Maryland

16. Informant

Address

Gladys Taylor
543-15th St NE Wash DC

17. General

(Burial, cremation, or removal. Which?)

Date thereof

11/19/47
(month) (day) (year)

Cemetery or cremation

Location

Washington D.C.
Annetta Taylor

18. Funeral director

Address

641 - 14th St NE
Washington D.C.

19.

(Date rec'd by registrar)

11/19 47

Amanda Downey
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Asphyxia

DURATION

Due to

Acute Carbon Monoxide poisoning

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 11-18-47

Where did injury occur? Landover P.G. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In woods

Name of physician who examined body and made report

Reputable medical examiner

23. SIGNATURE James P. Boyd
M.D. or other

Address Forestville, Md. Date signed 11-19-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 22 1947

ROSEBUD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10235

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Pr. GeorgeCity or town Hall
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 43

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.City or town Hall Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Edward Binger

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of ~~husband~~ wife Lexena Binger7. Birth date of deceased (mo., day, yr.) Jan 2 1874 6.(c) If alive, give age _____ years8. AGE: Years 73 Months 10 Days 10 If less than one day _____ hrs. _____ min.9. Birthplace Westphalia Pr Geo Co. Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name William Binger13. Birthplace Germany14. Maiden name Sarah Jane Buchanan15. Birthplace Pa. U.S.A.16. Informant Norman William BingerAddress Upper Marlboro Maryland17. Burial Date thereof Nov 14 - 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lebanon HillLocation Smithland, Md.18. Funeral director Ritchie BrothersAddress Upper Marlboro Md.19. Nov 13 19 47 Registrar John Smith
(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH November 12 19 47 at 12:18 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3 19 47 to November 12 19 47 and that I last saw him alive on November 10 19 47Immediate cause of death congestive heart failure DURATION 2 MthsDue to arteriosclerotic heart disease 15 Years (History)Due to Generalized arteriosclerosis 15 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

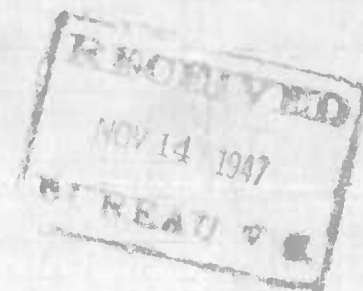
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Smit Pelche M.D. M. D. or other _____Address 6906 Pelche Rd SE Date signed _____
Wash 19 D.C.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 295

1. PLACE OF DEATH:

County Prince George's
City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Englewood Memorial Hosp.

How long in hospital or institution? 64 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 Forestway Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Amandus Bayer

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mrs. Mary Bayer

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

August 11, 1862

8. AGE:

Years

Months

Days

If less than one day

85

3

12

hrs.

min.

9. Birthplace

Catasauqui, Lehigh, Penn
(Town, county, and state)

10. Usual occupation

Electrical Eng - Retired

11. Industry or business

FATHER

12. Name

George G. Bayer

13. Birthplace

Lehigh, Pennsylvania

MOTHER

14. Maiden name

Agatha Newbolt

15. Birthplace

Pennsylvania

16. Informant

Mr. H. A. Bayer

Address

3 Forestway Road, Greenbelt, Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Nov 26 1947
(month) (day) (year)

Cemetery or crematory

3rd View Cemetery

Location

Catasauqua, Penna

18. Funeral director

J. Adasch Sons

Address

Hyattsville, Md.

19. Burial

(Date rec'd by registrar)

1947

James Serry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1947 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March

1946

to

Nov. 23,

1947

and that I last saw him

alive on

November 23,

1947

Immediate cause of death

Cerebral hemorrhage

DURATION

24 hrs

Due to

Chronic hypertensive disease - renal disease

6 years

Due to

Prostate hypertrophy - benign prostatic hyperplasia

3 years

Other conditions

hypertension, atherosclerosis

5 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

prostate hypertrophy grade 2

Date of op. 10/17/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James Serry, M.D.

M. D. or other

Address

307 Forestway Road, Greenbelt, Md

Date signed

11/23/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 26 1947
RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

478

10236

Reg. Dist. No.

234

1. PLACE OF DEATH:

County Prince George's
 City or town Silver Hill
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

4901- Branch Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Silver Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. 4901- Branch Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

John Brinzanik

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

?

7. Birth date of deceased (mo., day, yr.)

Jan ? 1875-

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

72

..... hrs.

..... min.

9. Birthplace

Stungray
(Town, county, and state)

10. Usual occupation

Stone cutter

11. Industry or business

MOTHER FATHER

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Mr. Thomas E. Wood

Address

4940 Branch Ave SE

17. Burial

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Nov 25, 1947
(month) (day) (year)

Cemetery or crematory

at Barnabas

Location

Suitland Md.

18. Funeral director

B. Gaschinson

Address

Hyattsville Md.

19.

Jan 21 1948
(Date rec'd by registrar)

19.

James Berry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 21, 1947 8:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Hemorrhage and shock
Carcinoma of lung

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

* injured at work?

23. SIGNATURE

Wesley Medical Chamber
James Berry
Address Forest Hills Md. Date signed 11-22-47

RECEIVED

DEC 4 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1700

10237

Reg. Dist. No. 231

1. PLACE OF DEATH:

County... Prince Georges

City or town... Langley
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Central Avenue and Brightseat Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District of Columbia

City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1736 Bonhomme Rd NW

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Anna Elaine Brooks

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Wilbur Brooks

7. Birth date of deceased (mo., day, yr.)

November 10, 1921

8. AGE:

Years

Months

Days

If less than one day

25

11

27

hrs.

min.

9. Birthplace

Washington D.C.
(Town, County, and state)

10. Usual occupation

domestic

11. Industry or business

FATHER

12. Name

Daniel Elyson

13. Birthplace

Washington D.C.

MOTHER

14. Maiden name

Anna Marie

15. Birthplace

Maryland

16. Informant

James D. Gibson

Address

2204 Jay Street NW Wash DC

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Nov. 7, 1947

Cemetery or crematory

Washington, D.C.

Location

Robert J. McGuire

18. Funeral director

1870 - 9th St. N.W.

Address

11/7

19. (Date rec'd by registrar)

1947

Amanda Downey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov 7 1947, at 3:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

Hemorrhage and shock

Due to... Crushed skull

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of 11-7-47

Where did injury occur? Langley P.S. and

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Central Ave

Means of injury... Car that turned over

Reported medical Examiner

23. SIGNATURE... James D. Gibson M.D. or other

Address... Forest Hill Ave Date signed 11-7-47

RECEIVED

NOV 10 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10238

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George
 City or town Farmington Hgts.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Prince George
 City or town Farmington Hgts.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 504-62nd Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert Charles Brown

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleNegroMarried6. (b) Name of husband or wife Georgia Brown7. Birth date of deceased (mo., day, yr.) 3-8-18916. (c) If alive, give age 52 years8. AGE: Years Months Days If less than one day
56 7 25 _____ hrs. _____ min.9. Birthplace Georgia
(Town, county, and state)10. Usual occupation laborer

11. Industry or business

12. Name Henry Brown13. Birthplace Georgia14. Maiden name Edna Linden15. Birthplace Georgia16. Informant Georgia BrownAddress 504-62nd Ave.17. Burial Date thereof Nov 8, 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lincoln MemorialLocation Suitland Md.18. Funeral director Malvan + Scheg IncAddress 424 R. St. N.W.19. Nov 4 19 47 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/47 10:45 PM 19 47 at 10/45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-5 19 47 to 11-1 19 47and that I last saw h...l...m... alive on 11-1 19 47Immediate cause of death Acute Heart Failure DURATIONDue to Cardiovascular Heart Disease

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

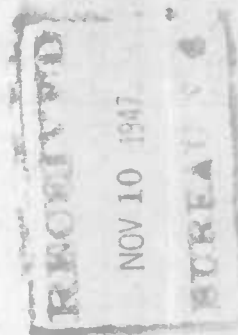
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Harry M. Jones M. D. or otherAddress 510-62nd Ave Date signed 11-3-47

I discussed the case with Dr. Boyd at 11 ^{PM}
and obtain an ok to release the body as a
private patient and not a coroners case.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10239

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
City or town Camp Springs, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Prince Georges
City or town Camp Springs, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Mary Elizabeth Bruce

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Jessiah Bruce -
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) June 15 - 1858

8. AGE: Years 89 Months 4 Days 23 It less than one day _____ hrs. _____ min.

9. Birthplace Nottingham - Md
(Town, county, and state)

10. Usual occupation market & house work

11. Industry or business

12. Name John H. Bowie

13. Birthplace Nottingham, Md

14. Maiden name Susan Gant

15. Birthplace Nottingham, Md

16. Informant Joseph A Bowie

Address Camp Springs, Wash DC-20

17. (Burial, cremation, or removal, Which?) Burial Date thereof Nov. 11, 1947
(month) (day) (year)

Cemetery or crematory St. Johns Church

Location Clinton, Maryland

18. Funeral director John J. Stewart

Address 36 N. 8th St - Wash DC

19. Nov. 11 1947 Carris E. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th 1947 at 11 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr - 20 1945 to Nov 9th 1947
and that I last saw him alive on Nov 8th 1947

Immediate cause of death Cerebral hemorrhage - DURATION 18 hrs
(two previous attacks)
Due to Arterio Sclerosis 6 yrs

Due to Age
Other conditions Heart Disease &
Chronic arthritis 10 yrs
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John E Bowers MD M. D. or other

Address Brandywine, Md Date signed 11/9/47

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 14 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10245

1. PLACE OF DEATH:

County..... Prince George
City or town..... Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Sacred Heart Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Delaware County.....
City or town..... Clayton
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Susan B. Cobb

3. (b) Social Security Number

4. Sex F. 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Dr. James S. Cobb

7. Birth date of deceased (mo., day, yr.) December 6th. 1866 6.(c) If alive, give age..... years

8. AGE: Years 80 Months 11 Days 14 If less than one day..... hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Benjamin H. Brown

13. Birthplace Maryland

14. Maiden name Caroline V. Walters

15. Birthplace Maryland

16. Informant Col. Lawrence L. Cobb.

Address Brown Station, Md.

17. Burial Date thereof Nov. 22. 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Carmel

Location Marlboro, Md.

18. Funeral director J. William Keiston Co.

Address 300 - 4th. St. N.E. Wash. D.C.

19. Nov. 20. 1947 Mrs. Jas. Severe Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20th. 1947 12-45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3 1947 to November 20 1947

and that I last saw h.er alive on November 20 1947

Immediate cause of death..... DURATION

Arteriosclerotic Heart Disease 18mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Thomas Tallin MD

Address 324-H ONE Date sign NOV 20 1947

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 24 1947
BUREAU V C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1860 10241 231
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
City or town Chesley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 days
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3915 - Longfellow St.
(If rural, give LOCATION)
2.(a) If veteran, name War

3. (a) FULL NAME

Mrs. Salina Cogar

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) Sept. 12, 1870 6.(c) If alive, give age years

8. AGE: Years 77 Months 1 Days 3 It less than one day hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Mrs. J. M. Mace
13. Birthplace Braxton Co. W. Va.
14. Maiden name Caroline Skidmore
15. Birthplace West Virginia

16. Informant Mrs. Madeline Barnett
Address 3915 - Longfellow St., Hyattsville
transportation Date thereof Nov 9, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Point Mountain
Location West Virginia

18. Funeral director F. Guscha sons
Address Hyattsville Md.

19. Nov 9 47 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 19 47 at 2 40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/2 19 47 to 11/8 19 47
and that I last saw him alive on 10/7 19 47
Immediate cause of death

Bronchopneumonia
Due to Old age - Debility
Due to Fracture of Neck of Femur
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations Fracture of neck of femur Date of op. 10/5/47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John Bayle M. D. or other
1726 Eye N.W. Address Date signed 11/8/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 13 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

159

1024245

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Riverdale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 Hrs. and 50 Minutes
 Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital
 How long in hospital or institution?..... 6 Hrs. and 50 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Prince Georges
 City or town..... Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... R. F. D. 2, Box 212
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Linda Jane Collins

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... Single
 6. (b) Name of husband or wife..... -
 7. Birth date of deceased (mo., day, yr.)..... November 30, 1947
 8. AGE: Years..... Months..... Days..... It less than one day..... 6 hrs. 50 min.

9. Birthplace..... Riverdale, Maryland
 (Town, county, and state)
 10. Usual occupation..... -
 11. Industry or business..... -
 12. Name..... Bryant Martin Collins
 13. Birthplace..... Virginia
 14. Maiden name..... Sarah Emaline Odell
 15. Birthplace..... Virginia

16. Informant..... Hosp. Records
 Address.....
 17. Burial Date thereof..... Dec 1, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Evergreen
 Location..... Bladensburg Rd
 18. Funeral director..... L. Pasche, Owner
 Address..... Hyattsville Md,
 19. Dec 1 1947 James Levy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 30, 1947 at 1:15 Pm
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 30 1947 to..... 19.....
 and that I last saw him alive on..... Nov 30 1947

Immediate cause of death..... prematurity DURATION.....

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place, (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... L W Malin MD M. D. or other
4404 Queensbury Road
 Address..... Riverdale, Maryland Date signed..... 11-30-47

RECEIVED

DEC 3 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10244 239

1. PLACE OF DEATH:

County Prince George's
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Nov. 6, 1946
 Hospital, institution, or street address where death occurred:
Laurel Sanitarium
 How long in hospital or institution? Since Nov. 6, 1946.

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)
 State Maryland Or Geo
 City or town Piscataway
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Conway, Frederick R.

3. (b) Social Security Number

4. Sex M 5. Color or race N 6. (a) Single, married, widowed, or divorcedUnmarried
Bachelor

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept 14 - 18758. AGE: 70 Years Months Days It less than one day _____ hrs. _____ min.9. Birthplace Columbia, Mo.
(Town, county, and state)10. Usual occupation Attorney

11. Industry or business _____

12. Name Frederick M. Conway13. Birthplace Mo. Hays14. Maiden name Susan Hays15. Birthplace Mo16. Informant Miss Julia C. ConwayAddress 140 E. 28th St. North City 16, N.Y.17. in a machine Date there Nov. 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium J. Williams Lee's Son. Co.Location Washington, D.C.18. Funeral director J. Williams Lee's Son. Co.Address 300 - 4th St N.E. Wash, D.C.19. Nov 4 47 M. Brashear
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 19 47 at 1:20 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 6 19 46 to Nov. 2 19 47and that I last saw him in alive on Nov. 2 19 47Immediate cause of death myocardial failure DURATION _____

Due to Arteriosclerosis

Due to _____

Other conditions Hemiplegia (rt)

(Include pregnancy within 3 months of death)

Major findings of operations none performedAutopsy results none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

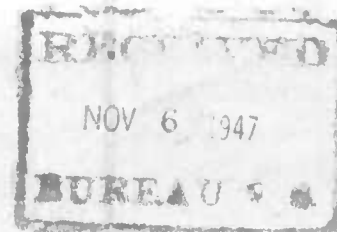
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jesse C. Rogers M. D. or other _____Address Laurel Md Date signed 10/2/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10243

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
County.....
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos., 25 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 mos., 25 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4862 McArthur Blvd., N. W.
(If rural, give LOCATION)
2(a) If veteran, name war.....

3. (a) FULL NAME
COOPER CARROLL R

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Helen C. Cooper
6. (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) August 29, 1892
8. AGE: Years Months Days If less than one day
55 55 2 17 hrs. min.

9. Birthplace Warsaw, Illinois
(Town, county, and state)
10. Usual occupation Draftsman
11. Industry or business - - -
12. Name Horace B. Cooper
13. Birthplace ? Illinois
14. Maiden name Anna L. Rogers
15. Birthplace ? Illinois

16. Informant Deceased
Address Removal
17. (Burial, cremation, or removal, Which?) Date thereof 11 - 15 - 47
(month) (day) (year)
Cemetery or crematory To Wash DC
Location
18. Funeral director Martin W. Hyatt
Address 1300 - N. H. N. W. Wash. DC
19. Nov 15, 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1947, at 6:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/20 1947, to 11/15 1947
and that I last saw him alive on 11/15 1947
Immediate cause of death Carcinoma, transitional cell (Grade II) of larynx DURATION 11 mos.
Due to
Due to
Other conditions Pulmonary tuberculosis, far advanced. 22 mos.
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finicane MD
M. D. or other
Address Glenn Dale Md Date signed 11/15/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 29 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10245

Reg. Dist. No. 231

1. PLACE OF DEATH:

County... Prince Georges

City or town... Chesapeake
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District of Columbia

City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1724 - 17th St NW

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank Joseph Coyhie

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ellen Mary Coyhie

6. (c) If alive, give age 47 years

7. Birth date of

deceased (mo., day, yr.)

October 31, 1893

8. AGE:

Years

Months

Days

If less than one day

54

hrs.

min.

9. Birthplace

New Jersey
(Town, county, and state)

10. Usual occupation

Horse Trainer

11. Industry or business

Horse Racing

FATHER

12. Name

unknown

13. Birthplace

unknown

MOTHER

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Mrs. Ellen Mary Coyhie

Address

724 - 17th St NW, Washington DC

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

11/21/47
(month) (day) (year)

Cemetery or crematory

Arlington Natl. Cen.

Location

Arlington, Va.

18. Funeral director

Dean Funeral Home

Address

4812 - LaVere Ave NW, Wash. D.C.

19. 11/18

(Date rec'd by registrar)

19 47

Amanda Dourney

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death

Acute congestive heart failure

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy medical Examiner

23. SIGNATURE James D. Boyd

Address 7015 17th St NW Date signed 11-18-47

RECEIVED

NOV 19 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10246 245

1. PLACE OF DEATH:

County PRINCE GEORGESCity or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 YEARS

Hospital, institution, or street address where death occurred:

4003 OLIVER ST.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGESCity or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)Street No. 4003 OLIVER ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ROLF GREYKE

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife ROSEAMOND GREYKE6. (c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) DEC. 16, 1885

8. AGE: Years Months Days If less than one day

61

..... hrs. min.

9. Birthplace VIRGINIA

(Town, county, and state)

10. Usual occupation TIRE SALESMAN11. Industry or business TIRE DISTRIBUTORS CO.12. Name ROLF GREYKE13. Birthplace ENGLAND14. Maiden name LYDIA EAST15. Birthplace ENGLAND16. Informant Mrs Roseamond GreykeAddress 4003 Oliver St. Hyattsville Md17. Burial Date thereof 11-24-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Oliver CemeteryLocation Washington, D.C.18. Funeral director Francis J. CollinsAddress 3821-14 H. St. N.W. Wash. D.C.19. Nov. 20, 1947 Mrs Jas Severe

(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1947 at 8:05 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28, 1947 to November 20, 1947and that I last saw him alive on November 20, 1947Immediate cause of death Coronary thrombosis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. SimpsonM. D. 11/20/47Address 1015 Monroe St. N.E. Date signed 11/20/47Wash. D.C.

CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF

STATE OF

DEPARTMENT OF HEALTH

RECEIVED
NOV 24 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10247

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince GeorgeCity or town Camp Springs
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louise V. DARCEY

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Warren Darcey

7. Birth date of

deceased (mo., day, yr.)

Jan. 10 - 1862

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

85921

hrs.

min.

9. Birthplace

Clinton Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Tenley

13. Birthplace

md.

MOTHER

14. Maiden name

Ellen Day

15. Birthplace

md.

16. Informant

Eugene Darcey

Address

5175- Auth Rd. Wash. 20.D.C.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 3 - 1947
(month) (day) (year)

Cemetery or crematory

Bell's m. E. Cemetery

Location

Camp Springs md.

18. Funeral director

Arthur E. Simmons Jr.

Address

2007- Nichols Ave. S.E. Wash. D.C.

19.

(Date rec'd by registrar)

19.47

Howard P. Ball

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Camp Springs
(If outside city or town limits, write RURAL and give nearest town)Street No. 5175- Auth Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st 19. 47 at 6²⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 19. 47 to Nov 1 19. 47
and that I last saw him alive on Oct 31 19. 47

Immediate cause of death

acute myocardial
decompensationDue to General ArterioSclerosisDue to and CoronaryBranchesOther conditions rectal fissure

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frederick G. Ball

M. D. or other

Address Washington 1947Date signed Nov 1 1947

RECEIVED

NOV 5 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges
 City or town Centland Manor
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4762 Homer Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Centland Manor
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4762 Homer Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Stephanie Eleanor de la Tour

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 9, 1915

8. AGE:

Years

Months

Days

If less than one day

32

hrs. min.

9. Birthplace

York Penn
 (Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

U. S. Government

12. Name

Washington

13. Birthplace

Washington

14. Maiden name

Washington

15. Birthplace

Washington

16. Informant

U. S. Army Records

Address

17.

Burial
 (Burial, cremation, or removal? Which?)

Date thereof

Nov. 13, 1947
 (month) (day) (year)

Cemetery or crematory

Arlington Natl.

Location

Arlington Va.

18. Funeral director

J. Paschi Sano.

Address

Hyattsville, Md.

19.

1012

19

47

Amanda Dorney

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 9 1947 at 6:05 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death

Dysentery

Due to

Acute hemorrhagic

Due to

poisoning

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

suicide Date of 11-9-47

Where did injury occur?

Centland P. S. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Home

Kept in hospital 2 weeks

23. SIGNATURE

Amanda Dorney

M. D. or other

Address

Hyattsville Md

Date signed 11-10-47

RECEIVED

NOV 13 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10248

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgesCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 minutes

Hospital, institution, or street address where death occurred:

Heland Memorial HospitalHow long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 22 Carroll Ave. Taka
(If rural, give LOCATION)2.(a) If veteran, name war. ☒

3. (a) FULL NAME

Miss Jennie Evans

3. (b) Social Security Number

4. Sex Fe 5. Color or race Wh 6. (a) Single, married, widowed, or divorced Single8. (b) Name of husband or wife July 3, 19047. Birth date of deceased (mo., day, yr.) July 3, 1904 6. (c) If alive, give age 47 years8. AGE: Years 43 Months 7 Days 16 It less than one day hrs. min.9. Birthplace Nanticoke, Pennsylvania (Town, county, and state) Luzerne County10. Usual occupation None

11. Industry or business

12. Name Hugh Evans13. Birthplace Wales, British Isles14. Maiden name Nannah Davies15. Birthplace Wales16. Informant David J. EvansAddress 22 Carroll Ave. Takoma Park, Md.17. Burial Date thereof 11-22-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft. Lincoln 11-22-47Location Bladensburg Rd & D.C. Line18. Funeral director S. W. Hines Co.Address 2901-14th St. N.W. - Washington, D.C.19. Nov 20 19 47 James Derry

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19-47 19 47, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 19 47Immediate cause of death Cerebellar and pontine hemorrhage; cause undetermined (no evidence of trauma).Due to Cerebellar and pontine hemorrhage; cause undetermined (no evidence of trauma).

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

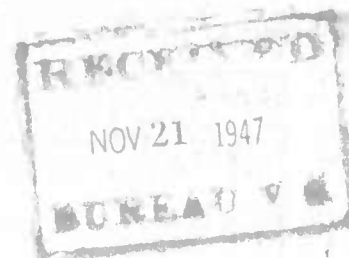
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. H. Cornell M.D.Address Pathologist Heland Mem. Hosp. M.D. or otherDate signed 20 Nov 47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10249 245

1. PLACE OF DEATH:

County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4512-31

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No. 4512-31

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William F. Farrell

3.(b) Social Security Number

220-10-54514. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Emma M. Farrell 6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) July 9th 1889
8. AGE: Years 58 Months Days If less than one day hrs. min.9. Birthplace California
(Town, county, and state)
10. Usual occupation carpenter
11. Industry or businessFATHER 12. Name William F. Farrell
13. Birthplace Ireland
MOTHER 14. Maiden name Mary Duly
15. Birthplace Ireland16. Informant Mrs. Emma M. Farrell
Address 4512-31st St. Mt. Rainier Md.17. Burial Date thereof Nov. 21-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Prospect Hill
Location Washington D.C.18. Funeral director Wm. J. Galley
Address 3200-8th Ave. Mt. Rainier Md.19. 11/21 19 47 Amanda Deoney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 19 47 at 10⁵⁵A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 11 19 47 to NOV. 19 19 47
and that I last saw him alive on NOV. 18, 1947 19 47Immediate cause of death Demodified Carcinomatosis DURATION ?Due to Ca. of stomach 15 mos?

Due to

Other conditions Cachexia of Ca. ?

(Include pregnancy within 3 months of death)

Major findings of operations Esophageal Ca. involving almost entire stomach Date of op. 2-28-47Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

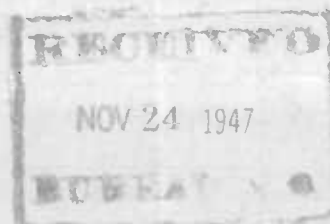
23. SIGNATURE D. J. Blayman M. D. or other redAddress 4118-30th St. Mt. Rainier Date signed 11/19/47
red

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:

County Prince GeorgeCity or town Charleely Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George HospitalHow long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Beentwood Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 4507-38th Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ferguson, Mrs Annie

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female white married6.(b) Name of husband or wife Ferguson, Enoch David7. Birth date of deceased (mo., day, yr.) September 8, 1881

8. AGE: Years Months Days If less than one day

66 1 23 hrs. min.9. Birthplace Prince George County, Md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Tucker, John F13. Birthplace Md14. Maiden name Lucinda King15. Birthplace Md16. Informant Hospital records

Address

17. Burial Date thereof Nov 4, 1947
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Episcopal CemeteryLocation Forestville Md18. Funeral director F. Pasch's SonsAddress Hyattsville Md19. Nov 2 47 Amanda Womney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1-47 19 47 at 10:50 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 47, to Nov 1 19 47and that I last saw her alive on Oct 31 19 47

Immediate cause of death

Pulmonary edema
Carcinomatous, Thoracic, abd-
Carcinoma of BreastDue to RT Hydrothorax

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma, Scirrhous
RT Breast Date of op. 1938Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

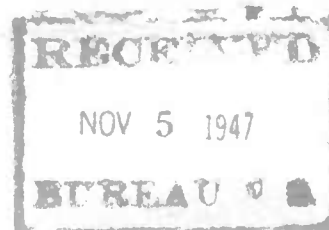
23. SIGNATURE Benjamin S. MillerAddress 3824 34th St Pinner M. D. or other Nov 1 1947
Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLACE OF DEATH:

County Prince George's
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Prince George's General Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Lanham
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Matt Finn
 7. Birth date of deceased (mo., day, yr.) Feb. 9, 1984 6.(c) If alive, give age _____ years
 8. AGE: Years 63 Months 9 Days 10 It less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1947 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Nov 19, 1947
 and that I last saw him alive on Nov 19, 1947

Immediate cause of death

Uremia

DURATION

2 days

Due to Hypertensive Cardia
Renal Disease

1 yr

Due to _____
 Other conditions Diabetes

5 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John J. Maloney M. D. or other
Chesley Hyattsville
 Address _____ Date signed 11-19-47

9. Birthplace Va. (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business _____
 12. Name John Seckford
 13. Birthplace Va.
 14. Maiden name Virginia Seckford
 15. Birthplace Va.
 16. Informant Hospital Records
 Address _____
 17. Burial Date thereof Nov 22, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Lincoln
Washington St.
 Location _____
 18. Funeral director F. G. Schuch's son
 Address Hyattsville Md.
 19. Nov 21, 1947 Amanda Daurey
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 25 1947

BUREAU •

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94w

10252

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Pr. Warren's Hospital
 City or town Laurel - Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 322 - Montg. St.
 (Rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Emma Elizabeth Fisher

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hugh A. Fisher

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 26 - 1923

8. AGE:

Years

Months

Days

If less than one day

6492

hrs.

min.

9. Birthplace

Rockwood, Pennsylvania
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name

George H. Gurley

13. Birthplace

Maryland

14. Maiden name

Sabina

15. Birthplace

16. Informant

Hugh A. Fisher

Address

322 Montg. St. - Laurel - Md.

17. (Burial, cremation, or removal, Which?)

Burial Date there Nov. 26 - 1947
(month) (day) (year)

Cemetery or crematorium

Day Tree Cemetery

Location

Laurel - Md.

18. Funeral director

Arthur Masters

Address

505 - N. Blvd. - Laurel - Md.

19. (Date rec'd by registrar)

Nov. 241947M. Brashers
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/47 19 47 at 3:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 11 19 47 to Nov. 24 19 47and that I last saw her alive on Nov. 23 19 47

Immediate cause of death

Coronary Thrombosis

DURATION

14 days

Due to

Due to

Other conditions

Chr. gall bladder10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

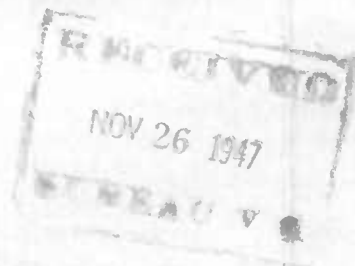
Injured at work?

23. SIGNATURE

J. M. Warren M.D.
M. D. or other

Address

Laurel Md. Date signed 1/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10253

Reg. Dist. No.

242

1. PLACE OF DEATH:

County Prince GeorgesCity or town Kitching
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

7 mo.

3. (a) FULL NAME

Dennis Ford

3. (b) Social Security Number

4. Sex ♂ 5. Color or race C 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Hester Greenfield7. Birth date of deceased (mo., day, yr.) March 18618. AGE: 86 Years 8 Months 8 Days 1 If less than one day hrs. min.9. Birthplace Pr. Geo. County
(Town, county, and state)10. Usual occupation Cook11. Industry or business James Ford12. Name James Ford13. Birthplace Pr. Geo. County14. Maiden name Barbara Greenfield15. Birthplace Pr. Geo. County16. Informant Churchhouse Records

Address

17. Burial Date thereof Nov. 19-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BadenLocation Pr. Geo. Co. Md.18. Funeral director Hunt & RyanAddress Waldorf, Maryland19. Nov. 17 1947 Edna F. Collins
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. GeorgeCity or town Baden, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1947 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Cyr. 12 1947 to Nov 17 1947
and that I last saw him alive on Nov 15 1947

Immediate cause of death

Hypertensive Heart Disease

DURATION

2

Due to _____

Due to _____

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

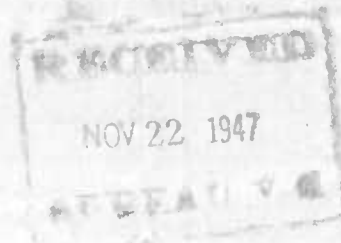
Means of injury _____

Injured at work? _____

23. SIGNATURE John D. Maloney M.D.

M. D. or other

Address Cherry-Hyattsville Date signed 11-17-1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10254 245

1. PLACE OF DEATH:

County Prince Georges

City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3209 Perry Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash. D.C. County

City or town
(If outside city or town limits, write RURAL and give nearest town)Street No. 3356 Erie St. S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sharron Fox

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 28, 1946

5. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1

9

hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

Louis Fox

13. Birthplace

New York, N.Y.

14. Maiden name

Dora Levin

15. Birthplace

Wash. D.C.

16. Informant

Louis Fox

Address

3356 Erie St. S.E.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 26, 1947

Cemetery or crematory

National Cap. Hebrew Cemetery

Location

Wash. D.C.

18. Funeral director

Bernard Haysman & Son

Address

3501-14 St NW Wash. D.C.

Nov 28 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 25 1947 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 28 1946 to Nov 25 1947

and that I last saw her alive on Oct 6 1947

Immediate cause of death

Congenital heart

disease

DURATION

Single
Birth

Due to

Due to

Other conditions

Mangalium idioey

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David R. Weinstein

M. D. or other

Address 5020 - 16th St NW Date signed 11-25-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

O. K. by

Mr. Van Hatten
Acting Comar

RECEIVED
NOV 26 1947
STANDARD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
County...
City or town... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... D. C. County...
City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No... 221 O. St., N. W., Apt. #6
(If rural, give LOCATION)
2.(a) If veteran, name war. ✓

3. (a) FULL NAME

GIBSON, FRED

3. (b) Social Security Number

579-05-1248

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Maude Macy Gibson
6. (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) March 4, 1910

8. AGE: Years Months Days If less than one day
37 37 8 21 hrs. min.

9. Birthplace Marion, South Carolina
(Town, county, and state)

10. Usual occupation Cook

11. Industry or business - - -

12. Name S. D. Williams

13. Birthplace Marion, South Carolina

14. Maiden name Anna Liza Leggett

15. Birthplace Marion, South Carolina

16. Informant Deceased

Address

17. Removal Date thereof 11/26/47
(Burial, cremation, or removal. Which?)
Cemetery or crematory Washington D.C.
Location

18. Funeral director Mahan & Schey Inc.

Address 424 - R St. N.W.
L.W.D. 115

19. Nov 26 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1947 at 5 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/7 to 11/25 and that I last saw him alive on 11/25

Immediate cause of death Tuberculous meningitis DURATION 3 days

Due to

Due to

Other conditions Pulmonary Tuberculosis with generalized miliary dissemination 2 months
(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results Confirmed the above diagnosis
PHYSICIAN: Please name the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinicare M.D.
M. D. or other

Address Glenn Dale, Md. Date signed 11/25/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The card is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 8 1947
BUREAU

RECEIVED

NOV 11 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of **MARYLAND STATE DEPARTMENT OF HEALTH**
date of birth or age shown on
838 10257
FILM No. G 113 NOV 17 1947 **CERTIFICATE OF DEATH**
Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town St. Catharines
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos.
Hospital, institution, or street address where death occurred:
Mother Jones Rest Home
How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2304 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Joseph F. Gordon

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) December 9, 1864 B. (c) If alive, give age..... years

8. AGE: Years 83 Months 10 Days 29 If less than one day..... hrs. min.

9. Birthplace Wendover N.C.
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Mother Jones Rest Home

Address Walden Md.

17. Burial Date thereof Nov 10, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory La. Cross beauty

Location La. Cross, Va.

18. Funeral director W. W. Chambers Co.

Address 517-11th St. S.E. Wash. D.C.

19. Nov-8 1947 James Sever
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/47 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/5/47 to 10/8/47

and that I last saw him live on 11/8/47

Immediate cause of death Cerebral Thrombosis

DURATION 2 days

Due to hypertension

Due to

Other conditions Heart Enlarged 5 days

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Howard Thomas

23. SIGNATURE 28 Carroll Ave Takoma Park M. D. or other

Address Date signed 11/8/47

RECEIVED

NOV 11 1947

BUREAU 7 C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *245*

1. PLACE OF DEATH:

County *Prince George's*

City or town *Riverdale*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Dead on arrival*

Hospital, institution, or street address where death occurred:

Leland Memorial

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State *District of Columbia*

City or town *Washington*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *3133 Connecticut Ave*

(If rural, give LOCATION)

2(a) If veteran, name war *World War # 1*

3. (a) FULL NAME

Alexander Maxwell Graham

3. (b) Social Security Number

4. Sex *Male*

5. Color or race *White*

6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Irene Graham*

6. (c) If alive, give age *56* years

7. Birth date of deceased (mo., day, yr.) *August 29, 1891*

8. AGE: Years *56* Months Days If less than one day

8. (c) If alive, give age *56* years

9. Birthplace *Superior, Wisconsin*

(Town, county, and state)

10. Usual occupation *Sales Manager*

11. Industry or business *Frank Murth Association*

12. Name *William Graham*

13. Birthplace *Wisconsin*

14. Maiden name *Mary Mc Coy*

15. Birthplace *Texas*

16. Informant *Irene Graham*

Address *3133 Conn. Ave., Washington, D.C.*

17. *Burial* Date thereof *11-7-47*

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory *Arlington National Cemetery*

Location *Arlington Va*

18. Funeral director *The S. H. Nines Co*

Address *2901 14th St N.W.*

19. *Nov 4* 19 *47* *Mrs. Jas. Severe*

(Date rec'd by registrar) *Deputy Social Registrar*

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 4, 1947, at 12:45 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Hemorrhage and shock

Due to *Crushed chest*

Due to *Fracture and dislocation of the*

second and third cervical vertebrae

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *11/4/47*

Where did injury occur? *Berwyn* *P.G.* *Md.*

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Route # 1*

Means of injury *Pedestrian struck by an automobile*

Deputy Medical Examiner *James S. V. 3rd*

23. SIGNATURE *James S. V. 3rd*

Address *Forestville, Md.*

Date signed *11/4/47*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10258

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: County <u>Prince George's</u> City or town <u>Lanham</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Transient</u> Hospital, institution, or street address where death occurred: <u>Lanham Avenue, 118 Manor St.</u> How long in hospital or institution? _____			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Prince George's</u> City or town <u>Lanham</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>615 Main Street</u> (If rural, give LOCATION) 2(a) If veteran, name war _____		
3. (a) FULL NAME <u>William James Graham</u>			3. (b) Social Security Number _____		
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife _____					
7. Birth date of deceased (mo., day, yr.) <u>June 1880</u>					
8. AGE: Years <u>67</u> Months _____ Days _____ If less than one day _____ hrs. _____ min. _____					
9. Birthplace <u>Prince George's County, Md.</u> (Town, county, and state)					
10. Usual occupation <u>Washwasher</u>					
11. Industry or business <u>Lunch Room</u>					
MOTHER FATHER	12. Name <u>Joseph Graham</u>				
	13. Birthplace <u>Canada</u>				
	14. Maiden name <u>Mirandy Chaney</u>				
	15. Birthplace <u>Maryland</u>				
16. Informant <u>Helen Graham</u> Address <u>615 Main Street, Lanham, Md.</u>					
17. <u>Burial</u> Date thereof <u>Nov. 28 1947</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Fry Hill Cemetery</u> Location <u>Lanham, Md.</u>					
18. Funeral director <u>Arthur Stalder</u> Address <u>505 Washington Blvd., Lanham, Md.</u> <u>Nov 26 1947</u> M. Brashers Registrar					
22. MEDICAL CERTIFICATION 20. DATE OF DEATH <u>November 26 1947</u> at <u>2:30 A.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____ and that I last saw him _____ alive on _____ 19 _____ Immediate cause of death <u>acute congestive heart failure</u> Due to <u>cardiovascular renal disease</u> Due to _____ Other conditions _____ (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____ Injured at home, farm, industry, public place (where?) _____ Means of Injury _____ Injured at work _____ 23. SIGNATURE <u>James J. Boyd</u> M. D. or other _____ Address <u>Washington</u> Date signed <u>11.26.47</u>					

ARTISTIAN LEADER

RECEIVED

RECEIVED

NOV 29 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10259

245

1. PLACE OF DEATH:

County Prince GeorgesCity or town North Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

4509 - 40th Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town North Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4509 - 40th Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BESSIE GROSS

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1882

8. AGE:

Years

Months

Days

If less than one day

64-65

hrs.

min.

9. Birthplace Calvert Co., Md.

(Town, county, and state)

10. Usual occupation None.

11. Industry or business

12. Name Jerry Coates13. Birthplace Calvert Co., Md.14. Maiden name Maggie Smith15. Birthplace Calvert Co., Md.16. Informant Blanche MahoneyAddress 614 Trumble st. NW, Wash., D.C.17. Removal (Burial, cremation, or removal) Which?

Date thereof

Nov 10, 1947

Cemetery or crematory

Location

18. Funeral director

Address

19. Nov 10 1947

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1947 at 7:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

ToxemiaDue to Corbush on butter

Due to

Other conditions Elizabeth of long

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Westville, N.C. Date signed 11-10-47

RECEIVED

NOV 12 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 rr

10260

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges Co

City or town Mt Rainier Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prs Geo Co

City or town Mt Rainier Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 3210 Bunker Hill Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Emily Gregory Haas

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Joseph Haas

7. Birth date of deceased (mo., day, yr.)

October 9, 1873

6. (c) If alive, give age 73 years

8. AGE:

Years

Months

Days

If less than one day

74

- 0

25

hrs.

min.

9. Birthplace

Morristown New Jersey

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Lucemel E. Miller

13. Birthplace

Morristown New Jersey

14. Maiden name

Martina Gregory

15. Birthplace

New Jersey

16. Informant

Joseph Haas

Address

Mt Rainier Md

17. Burial, cremation, or removal. Which?

Burial

Date thereof

Nov 7, 1947

Cemetery or crematory

Fort Lincoln

Location

Washington D.C.

18. Funeral director

F. Gascha, sons

Address

Hyattsville Md

19. (Date rec'd by registrar)

Nov 7, 1947

Mrs. Jas. Severel

Duty Social

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 4, 1947

at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-21

1947

to

11-4 1947

and that I last saw him alive on

11-3 1947

Immediate cause of death

Pituitary carcinoma of abdominal organs

Due to

Carcinoma of gonads

Due to

in G.I. tract

DURATION

2 mos?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. Severel M.D. or other

Address

Mt. Rainier Md

Date signed 11-5-47

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NOV 8 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10261

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince George's
City or town Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 99 days
Hospital, institution, or street address where death occurred:
Frederick Le Sand Memorial Hospital
How long in hospital or institution? 99 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D.C. County Washington, D.C.
City or town _____
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1613 Harvard St. N.W.
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Miss Bettie Mae Harker
4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____ 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 4, 1929

8. AGE: Years 68 Months 6 Days 7 It less than one day _____ hrs. _____ min.

9. Birthplace Newark, Delaware
(Town, county, and state)

10. Usual occupation Bureau of Intere Revenue

11. Industry or business _____

FATHER 12. Name Franklin P. Harker
13. Birthplace Lakeland, Md.

MOTHER 14. Maiden name Julie Virginia King
15. Birthplace Virginia

16. Informant Miss Franklin Harker
Address 1613 Harvard St. N.W.

17. Burial, cremation, or removal, Which? Burial Date thereof Nov 14, 1947
(month) (day) (year)

Cemetary or crematory Whitfield Cemetery

Location Lanham, Maryland

18. Funeral director The A. J. Harris Co.

Address 2901 14th Street N.W. Washington, D.C.

19. Nov 11 19 47 Mrs. Joe Severo
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 19 47 at 1:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 19 47 to Nov 11 19 47
and that I last saw him alive on Nov 11 19 47

Immediate cause of death General Carcinomatosis DURATION 3 mo

Due to Carcinoma of uterus 1 year

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

23. SIGNATURE L W Malin MD M. D. or other
Address Riverdale, Md Date signed Nov 11, 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 13 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town Fletcherstown (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Fletcherstown (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Benjamin Hawkins

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Jane Hawkins

7. Birth date of

deceased (mo., day, yr.)

May 1885

8. (c) If alive, give age years

8. AGE:

62

Months

Days

if less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Walter

11. Industry or business

FATHER

12. Name

Knotley Sweeney Hawkins

13. Birthplace

Maryland

MOTHER

14. Maiden name

Martha Ann Fletcher

15. Birthplace

Maryland

16. Informant

Lawrence HawkinsAddress 1021 7th Street N. E. Wash., D. C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

11 26 47
(month) (day) (year)

Cemetery or crematory

Ascension

Location

Bowie Md

19. Funeral director

Address

Martin Fletcher Sons
Bowie Md

20. Rec'd by registrar

Nov. 25 19 47
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 19 47 at 7:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Hemorrhage

DURATION

Due to Ulcerating carcinoma of the throatDue to Carcinoma of the tongue (squamous cell)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

Address Forestville, Md. Date signed 11/24/47

RECEIVED
DEC 3 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10263 232

1. PLACE OF DEATH:

County Prince George's
 City or town Mitchellville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:
Cram Highway
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1625 Ashlan Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Leroy Wilbur Holmer

3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) Oct 5, 1914 6. (c) If alive, give age _____ years
 8. AGE: Years 33 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md
 (Town, county, and state)
 10. Usual occupation Orderly
 11. Industry or business John's Hopkins Hospital
 12. Name Wilbur Holmer
 13. Birthplace Maryland
 14. Maiden name Annie Bradford
 15. Birthplace Maryland

16. Informant Mr Annie Bird
 Address Mitchellville Md
 17. Burial Date thereof Nov 19, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Union
 Location Dardemville, Md.

18. Funeral director J. B. Johnson
 Address Frederick, Md
 19. Nov 18 19 47 Henry Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18, 1947 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death Congestive heart failure
Cardiovascular renal
disease
 Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Henry Smith 2 3rd
 Address Mitchellville Md Date signed 11-14-47
 M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County Prince George's General Hospital
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 days and 15 min.
 Hospital, institution, or street address where death occurred:
Prince George's General Hospital
 How long in hospital or institution? 20 days and 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Lothian
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Owens Hopkins

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Robert D Hopkins

7. Birth date of deceased (mo., day, yr.)

Oct. 31, 1902

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

45

0

4

hrs.

min.

9. Birthplace Oneida, New York

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name Walter Scott Owens

13. Birthplace

Maryland

MOTHER

14. Maiden name Emma D. Fridinger

15. Birthplace

Maryland

16. Informant

Robert D. Hopkins (Husband)

Address

Lothian, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov 6 1947

(month) (day) (year)

Cemetery or crematory

Mt. Calvary

Location

Bristol, Md.

18. Funeral director

Address

F. A. Hardisty & Son
Salisbury, Md.

19.

11/4
(Date recd by registrar)

19

47Amanda Downey
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

4 Nov19 47 at 9:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 May 19 47 to 4 Nov 19 47and that I last saw him alive on 4 Nov 47 19

Immediate cause of death

Coronary Arteriosclerosis

DURATION

2 weeks

Due to

Rheumatic Cardiovascular Disease2 wk

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

R. B. Lauer
Upper Marlboro, Md.
Address _____ Date signed 11 Nov 47

M. D. or other _____

RECEIVED

NOV 6 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10265
 Reg. Dist. No. 231

1. PLACE OF DEATH:

County..... Prince George
 City or town..... Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 minutes
 Hospital, institution, or street address where death occurred:
Prince George's General Hospital
 How long in hospital or institution? 35 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Prince George
 City or town..... Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 4003 Queensburg Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

JENNIE HUNTER

3. (b) Social Security Number

4. Sex..... Female
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... Charles Hunter
 7. Birth date of deceased (mo., day, yr.)..... DEC. 8 - 1870
 6.(c) If alive, give age..... years
 8. AGE: Years..... 77 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... West Virginia
 (Town, county, and state)
 10. Usual occupation..... Retired housewife
 11. Industry or business.....
 12. Name..... Charles Crim
 13. Birthplace..... West Virginia
 14. Maiden name..... unknown
 15. Birthplace..... West Virginia
 16. Informant..... Walter C. Payne (Son-in-law)
 Address..... Brookfield, Md.

17. Burial Date thereof..... 11/29/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Fort Lincoln Cemetery
 Location..... Washington DC
 18. Funeral director..... W.W. O'Leary & Sons
 Address..... Riverside - Md
 19. 11/29 19. 47 Amanda Houna
 (Date rec'd by registrar) Registry

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 26, 19. 47 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5 years 19. to 19.
 and that I last saw her alive on 11-26-47 19.

Immediate cause of death..... Cerebral hemorrhage DURATION..... 3 hours

Due to..... Hypertension and cerebral arteriosclerosis years.....

Due to..... years.....

Other conditions..... coronary heart disease years.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Leonard R. M.D.
4314 Gallatin Hyattsville 11/27/47
 Address..... Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10266

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
County
City or town Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos., 13 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 11 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 744 Howard, S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

ALEXANDER JACKSON

3. (b) Social Security Number

4. Sex Male
5. Color or race Colored
6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 29, 1915
6. (c) If alive, give age years

8. AGE: Years 32 Months 32 Days 18
If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Vender

11. Industry or business

12. Name Alexander Jackson
13. Birthplace Unknown

14. Maiden name Rebecca Hawkins
15. Birthplace Waldorf, Maryland
Deceased

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/17/47
(month) (day) (year)
Cemetery or crematory Piney Church
Location Waldorf, Md.

18. Funeral director Henry & Ryan
Address Waldorf, Maryland

19. Nov 17, 1947 1 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 16, 1947 at 4:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DECEMBER 12, 1947, to Nov. 16, 1947, and that I last saw him alive on Nov. 16, 1947.

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 8 yrs 11 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane M.D.
M. D. or other

Address Glenn Dale, Md. Date signed 11/16/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 29 1947

STREAC - S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 102672 2722

1. PLACE OF DEATH:

County Maryland - Prince Geo.
 City or town Cedar Heights
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6211 - L St. N.E.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Cedar Heights
 (If outside city or town limits, write RURAL and give nearest town)Street No. 6211 L Street
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Benjamin Frank Johns.

3. (b) Social Security Number

4. Sex male. 5. Color or race Col. 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 - 18868. AGE: Years 61. Months Days If less than one day
 hrs. min.9. Birthplace Maryland
 (Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Thomas John
 13. Birthplace Maryland
 14. Maiden name Sueley Blake
 15. Birthplace Maryland16. Informant Robert JohnAddress 2021 - Claggett St. N.E.17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 18, 1947
 (month) (day) (year)Cemetery or crematory Lincoln Memorial CemeteryLocation Spittens Road18. Funeral director John S. Blumel & CoAddress 901 - 3 St. S.W.19. Nov 16 19 47 Edna L. Collins
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1947 at 11:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 18, 1947 to November 14, 1947
 and that I last saw him alive on November 14, 1947

Immediate cause of death

Malnutrition
Dehydration
 Due to Generalized Carcinomatous
Metastasis
 Due to Gastric Carcinoma

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Stomach

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Were did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver Thornton

M. D. or other

Address 1937 Penn Ave N.E. Date signed 11-14-47
Wash DC

RECEIVED

NOV 22 1947

BUREAU V C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122b

10268

CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH:

County Prince GeorgesCity or town Crofton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

6655 Tucker Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Crofton
(If outside city or town limits, write RURAL and give nearest town)Street No. 6655-Tucker Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Roland Johnson

3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age 17 yrs. years7. Birth date of deceased (mo., day, yr.) January 13, 19468. AGE: Years 1 Months 0 Days 0
If less than one day
hrs. min.9. Birthplace Washington, DC.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name John T. Johnson13. Birthplace Maryland14. Maiden name Helen E. Halley15. Birthplace Maryland16. Informant Helen E. JohnsonAddress 6655-Tucker Road Wash 2017. Burial Date thereof Dec 2 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn CemeteryLocation Washington, DC.18. Funeral director John J. Phinney & CoAddress 901-3rd St. S.W.19. Dec 2 19 47 Edna F. Collins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 19 47 at 6:15 A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

SepsisDue to Recurrent vomitingDue to Intestinal obstruction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner23. SIGNATURE James E. Joseph M.D. of StateAddress Shesville Ky Date signed 11-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 9 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1026932

1. PLACE OF DEATH:

County Prince George's
City or town Croome Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Croome Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) Is veteran, name war

3. (a) FULL NAME

Infant Jones

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) November 24, 1947
8. AGE: Years Months Days It less than one day
..... hrs. 24 min.

9. Birthplace Croome Station, Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

MOTHER FATHER
12. Name Ellesworth Jones
13. Birthplace Maryland
14. Maiden name Noon Spencer
15. Birthplace Maryland

16. Informant Ellesworth Jones
Address Croome Station, Md

17. Burial (Burial, cremation, or removal, Which?) On farm, Croome Station
Date thereof Nov 25, 1947 (month) (day) (year)

Cemetery or crematory Croome Station, Md

Location Ellesworth Jones

18. Funeral director Ellesworth Jones

Address Croome Station, Md

19. Nov 25 47 (Date rec'd by registrar) Registrar Reuben Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1947 at 8:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....
and that I last saw him alive on 19.....

Immediate cause of death Prematurity DURATION

Due to

Due to

Other conditions Baby was about 30 centimeter long
(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner

Address Frederick, Md Date signed 11-26-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 29 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10270

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 hours
 Hospital, institution, or street address where death occurred:
Prince George's General Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Lanham
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Ada King

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 5, 1867 6.(c) If alive, give age _____ years

8. AGE: Years 80 Months 4 Days 4 It less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name John R. Offutt
 13. Birthplace Washington, D.C.
 14. Maiden name Sarah Robe
 15. Birthplace Washington, D.C.

16. Informant Maurice A. Morris
 Address Lanham, Md.

17. Burial Date thereof Nov. 19, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
 Location Arlington, Va.

18. Funeral director William J. Nalley
 Address 3200 - R.I. Ave. Apt. 2, Baltimore, Md.

19. 11/18 19 47 Amanda Douney
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1947 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

a site congestive heart failure

Due to Coronary sclerosis

Due to Cardiovascular renal disease

Other conditions Submyeloid abscess

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

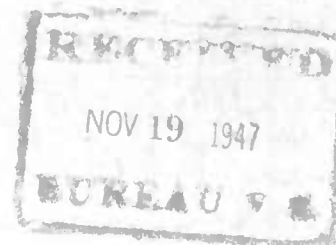
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John R. Offutt M.D. or other _____

Address Frederick, Md. Date signed 11-17-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **Prince Georges**
City or town..... **Hyattsville**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... **Md.** County..... **Prince Georges**
City or town..... **Hyattsville**
(If outside city or town limits, write RURAL and give nearest town)
Street No..... **4200 Decatur Street**
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

MR. ALVIN LANK

3. (b) Social Security Number

4. Sex..... **M** 5. Color or race..... **W** 6.(a) Single, married, widowed, or divorced..... **M.**
6.(b) Name of husband or wife..... **Ester M. Lank**
6.(c) If alive, give age..... **62** years
7. Birth date of deceased (mo., day, yr.)..... **June 17, 1887**
8. AGE: Years..... **65** Months..... **4** Days..... **27** If less than one day..... hrs. min.

9. Birthplace..... **Del.**
(Town, county, and state)
10. Usual occupation..... **Vice Pres. Lank Co.**
11. Industry or business..... **Woodwork Co.**
12. Name..... **Wm J. Lank**
13. Birthplace..... **Del.**
14. Maiden name..... **Elizabeth Stanton**
15. Birthplace..... **Del.**

16. Informant..... **Murell E. Lank**
Address..... **2209 Douglass St NE.**
17. Burial..... **Burial** Date thereof..... **Nov 11, 1947**
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... **Cedar Hill Cem.**
Location..... **Suitland Maryland**
18. Funeral director..... **The S. H. Hines Co.**
Address..... **2901 14th St NW.**
Date rec'd by registrar..... **Nov 7, 1947** Registrar..... **James Berry**

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Nov 7, 1947** at..... **1:30 P.M.**
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... **Jan 7, 1947** to..... **Nov 7, 1947**
and that I last saw him alive on..... **Nov 6, 1947**

Immediate cause of death..... **Coronary thrombosis**
DURATION..... **1 week**
Due to..... **Generalized arterio-sclerosis**
DUE TO..... **10 yrs**
Other conditions.....

(Include pregnancy within 3 months of death)
Major findings of operations..... **none**
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

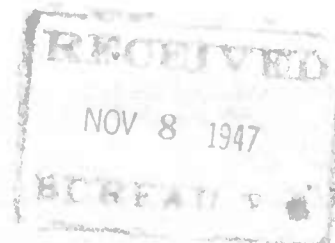
23. SIGNATURE..... **R. F. Daffey M.D.**
M. D. or other.....
Address..... **4200-95th NW** Date signed..... **11/7/47**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10272

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
County.....
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 9 months, 17 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 year, 9 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 4105 Wisconsin Avenue, N. W.
(If rural, give LOCATION)
2.(c) If veteran, name war.....

3. (a) FULL NAME

WILLIS LITTLETON LEWIS

3. (b) Social Security Number

578-09-2063

4. Sex Male
5. Color or race Colored
6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Katie Lewis
6. (c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) May 29, 1884
8. AGE: Years Months Days If less than one day
63 63 5 13 hrs. min.

9. Birthplace Stephens City, Virginia
(Town, county, and state)
10. Usual occupation Janitor
11. Industry or business - -
12. Name Fielden Lewis
13. Birthplace Stephens City, Virginia
14. Maiden name Mary Washington
15. Birthplace Stephens City, Virginia
16. Informant Deceased

17. Removal Date thereof 11/12/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Washington, D.C.
18. Funeral director A. B. Davis & Co.
Address 1432 1/2 W. St. Wash, D.C.
19. Nov. 12, 1947 Rowland S. Phelps
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 11 1947 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JANUARY 24 1946 to Nov 11 1947 and that I last saw him alive on Nov 11 1947

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 2 yrs

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

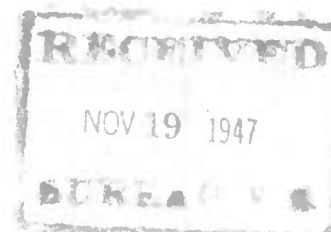
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane M.D.
M. D. or other
Address Glenn Dale Md Date signed 11/11/47

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10273

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
County.....
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 1 month, 30 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 years, 1 month, 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1507 32nd St., N. W.
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME
LILLE, DAVID

3. (b) Social Security Number
579-14-6556

4. Sex Male
5. Color or race Colored
6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife - - -
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) March 11, 1906
8. AGE: Years Months Days If less than one day
41 41 7 30 hrs. min.

9. Birthplace Laurinburg, North Carolina
(Town, county, and state)
10. Usual occupation Kitchen Helper
11. Industry or business - - -
12. Name Green Lille
13. Birthplace ? North Carolina
14. Maiden name ?
15. Birthplace ? North Carolina

16. Informant Deceased
Address
17. Removal Date thereof 11-11-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory to Washington DC
Location
18. Funeral director Monistad + Co.
Address 600-2nd St. SW
19. Nov 11, 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1947, at 2:25 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/10 1945 to 11/10 1947
and that I last saw him alive on 11/10 1947

Immediate cause of death pulmonary tuberculosis
DURATION 47 mos.

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pineane MD
M. D. or other
Address Glen Dale Md Date signed 11/10/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2 + 12-15-002

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

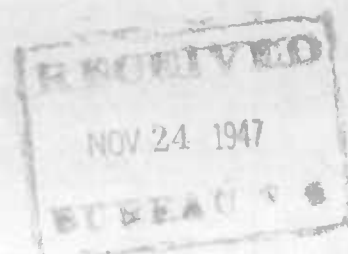
CERTIFICATE OF DEATH

Reg. Dist. No. *245*

10274

830

1. PLACE OF DEATH: County <i>Pro Geo Co</i> City or town <i>Rivardale Md</i> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <i>36 years</i> Hospital, institution, or street address where death occurred: How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <i>Md</i> County <i>Pro Geo Co</i> City or town <i>5600 Rittenhouse st</i> (If outside city or town limits, write RURAL and give nearest town) Street No. <i>Rivardale Md</i> (If rural, give LOCATION) 2. (a) If veteran, name war	
3. (a) FULL NAME <i>Nathan George McKnew</i>		3. (b) Social Security Number	
MEDICAL CERTIFICATION			
4. Sex <i>Male</i>		5. Color or race <i>white</i>	
6. (a) Single, married, widowed, or divorced <i>widower</i>		20. DATE OF DEATH <i>Nov 20, 1947</i>	
6. (b) Name of husband or wife <i>Mary E. McKnew</i>		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>Nov 15, 1946, to Nov 20, 1947</i>	
7. Birth date of deceased (mo., day, yr.) <i>Feb 27, 1883</i>		and that I last saw him alive on <i>Nov 20, 1947</i>	
8. AGE: Years <i>64</i> Months <i>8</i> Days <i>23</i> If less than one day <i>hrs. min.</i>		Immediate cause of death <i>cerebral haemorrhage</i>	
9. Birthplace <i>Baltimore Md</i> (Town, county, and state)		Due to <i>arterio Sclerosis</i>	
10. Usual occupation <i>Electrical Superintendent</i>		Due to <i>r</i>	
11. Industry or business		Other conditions <i>none</i>	
12. Name <i>Nathan Lincoln McKnew</i>		(Include pregnancy within 8 months of death)	
13. Birthplace <i>Md.</i>		Major findings of operations <i>✓</i>	
14. Maiden name <i>Cora Young</i>		Date of op.	
15. Birthplace <i>Md.</i>		Autopsy results <i>✓</i>	
16. Informant <i>Arthur McKnew</i>		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
Address <i>Rivardale Md.</i>		22. VIOLENCE: If death was due to external causes, fill in the following:	
17. Burial <i>Burial</i> Date thereof <i>Nov 22, 1947</i> (Burial, cremation, or removal. Which?) (month) (day) (year)		Accident, suicide, or homicide. Date of	
Cemetery or crematory <i>Fort Lincoln</i>		Where did injury occur? (City or town) (County) (State)	
Location <i>Washington D.C.</i>		Injured at home, farm, industry, public place (where?)	
18. Funeral director <i>F. Kusche Sons</i>		Means of injury Injured at work?	
Address <i>Hyattsville Md.</i>		23. SIGNATURE <i>Samuel R. Palmer</i>	
19. Date rec'd by registrar <i>Nov 26, 47</i> <i>Jaw Seny</i> Registrar		Address <i>4313 - Ballston</i> Date signed <i>11-21-47</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10275

Reg. Dist. No. 237

1. PLACE OF DEATH:

County.....DR. GEORGE'S
City or town.....AQUASCO, MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....87 YRS
Hospital, institution, or street address where death occurred:
AQUASCO, MD
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....MD County.....Prince Georges
City or town.....Aquasco
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

CHARLES ALEXANDER McPHERSON

3. (b) Social Security Number

4. Sex.....M 5. Color or race.....W 6.(a) Single, married, widowed, or divorced.....WIDOWED

6.(b) Name of husband or wife.....EVELYN A McPHERSON

7. Birth date of deceased (mo., day, yr.).....July 26, 1861 6.(c) If alive, give age..... years

8. AGE: Years.....86 Months.....3 Days.....9 If less than one day..... hrs..... min.

9. Birthplace.....Aquasco, Md.
(City, county, and state)

10. Usual occupation.....Farming

11. Industry or business

12. Name.....Charles Henry McPherson

13. Birthplace.....Aquasco, Md.

14. Maiden name.....Julia Roman Dorcas

15. Birthplace.....New York

16. Informant.....Henry McPherson

Address.....Aquasco, Md

17. (Burial, cremation, or removal, which?).....Burial Date thereof.....11/6/47
(month) (day) (year)

Cemetery or crematory.....St. Mary's

Location.....Aquasco, Md

18. Funeral director.....Walter & Ryan

Address.....Waldorf, Md.

19. Nov 4 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Nov 4 1947, at 8:45P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
SEPT 15 1947 to Nov 4 1947
and that I last saw him alive on Nov 4 1947

Immediate cause of death.....CEREBRAL ANOXIA

Due to.....CARDIOVASCULAR COLLAPSE

Due to.....ARTERIOSCLEROSIS GENERALIZED

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....Alfred R. Luper, M.D.

Address.....Aquasco, Md Date signed.....Nov 4, 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Chief Clerk
U.S. District Court
Southern District of New York
New York City

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10276

Reg. Dist. No.

389

1. PLACE OF DEATH:

County Prince George
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 64 years
 Hospital, institution, or street address where death occurred:
1105 Montgomery
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1105 Montgomery
 (If rural, give LOCATION)
 2. (a) If veteran, name war.

3. (a) FULL NAME

Jessie May Reed Merson

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Clarence Merson
 B. (c) If alive, give age 63 years
 7. Birth date of deceased (mo., day, yr.) June 25, 1883
 8. AGE: Years 64 Months 4 Days 19 It less than one day hrs. min.

9. Birthplace Laurel, Prince George, Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business

MOTHER FATHER
 12. Name Richard Reed
 13. Birthplace Virginia
 14. Maiden name Harriet Adelaide Cross
 15. Birthplace Savage, Maryland

16. Informant Mr. Clarence Merson
 Address 1105 Montgomery, Laurel, Md.
 17. Burial Date thereof Nov. 16 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Trinity Hill
 Location Laurel, Maryland
 19. Funeral director De Witt Donaldson
 Address Laurel, Maryland

19. Nov 16 19 47 M. Brashear
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 19 47 at 5:24 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 - 46 to Nov 14 19 47
 and that I last saw him alive on Nov 13 19 47
 Immediate cause of death Corn, retention
 DURATION 3
 Due to Chronic Hypertension
Chronic Mitral Regurgitation
Due to Myocardial Infarction
Cardiac
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dr. M. Brashear
 Address Laurel, Md. Date signed 11/15/47

RECEIVED
NOV 18 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10277

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges
 City or town Riverdale Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 days
 Hospital, institution, or street address where death occurred:
Island Memorial Hospital
 How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Haward
 City or town Savage
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓ ✓

3. (a) FULL NAME

Miss Mary Etta Newshaw

3. (b) Social Security Number

4. Sex F 5. Color of face W 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) June 7 - 1890
 8. AGE: Years 57 Months 5 Days 22 If less than one day
hrs. min.

9. Birthplace Savage Md.
 (Town, county, and state)
 10. Usual occupation Waitress
 11. Industry or business Laurel Sanitarium
 12. Name Stewart Ebenezer Newshaw
 13. Birthplace Anne Arundel Co.
 14. Maiden name Margaret Jane Bounds
 15. Birthplace Anne Arundel Co.
 16. Informant Chart records

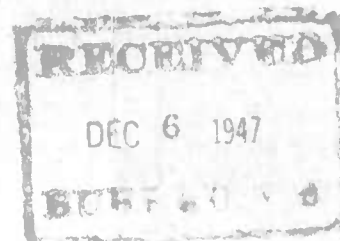
Address Laurel
 17. Burial Date thereof Dec. 2, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Savage
 Location Savage Md.
 18. Funeral director W. H. W. W. W. W.
 Address Laurel Md.
 19. (Date rec'd by registrar) Frank Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1947 at 8:05 p. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 to 19
 and that I last saw him alive on 19
 Immediate cause of death Toxemia
 Due to Crushed pelvis
and abdomen
 Due to
 Other conditions Fracture of left leg
and right arm, large
lacerations of buttocks
 (Include pregnancy within month of death)
 Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 11-8-47
 Where did injury occur? Laurel Md. (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Laurel Md.
 Reported by Police (Name of person reporting)
 Reporting medical examiner Forestville Md.
 23. SIGNATURE James P. [Signature] M. D. or other
 Address Forestville Md. Date signed 11-29-47



Office Hours:
6 to 7:30 P. M.

Except Sunday and Wed.

DR. FRANK E. SHIPLEY

Phone, Elkridge 149-M

Reg. No. 5335

SAVAGE,

MARYLAND

Name.....*State Registrar of Vital Stat*.....Age.....

Address.....*Balto., Md.*.....Date.....

*Dear Dr.: I gave Mr. Delwitt Branstson,
of Laurel, Md., a Burial Permit
but I do not know to whom to send
the original, so I am sending it
to you.*

Yours.

Frank Shipley

MARYLAND DRUG CO.

126 Washington Blvd., LAUREL, MD.

Phone 72

M. D.

Refill 0-1-2-3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10278

Reg. Dist. No. 245

1. PLACE OF DEATH:

County PRINCE GEORGESCity or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 YRS.Hospital, institution, or street address where death occurred:
SACRED HEART HOMEHow long in hospital or institution? 5 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Hyattsville Ind.
(If outside city or town limits, write RURAL and give nearest town)Street No. Sacred Heart Home
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

STANISLAUS MICHAELOWICZ

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife THEODOSIA

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) MAY 1, 1863

8. AGE: Years Months Days If less than one day

84.....hrs.min.

9. Birthplace.....

POLAND
(Town, county, and state)

10. Usual occupation.....

SHOEMAKER

11. Industry or business

12. Name.....

PETER MICHAELOWICZ

13. Birthplace.....

POLAND

14. Maiden name.....

BRIGITTA KARKOWSKI

15. Birthplace.....

POLAND16. Informant SACRED HEART HOME RECORDSAddress HYATTSVILLE, MD17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 11/14/47
(month) (day) (year)Cemetery or crematory St. Olivet CemeteryLocation Washington, D.C.

18. Funeral director.....

Address 3821-14th St. N.W. Wash. D.C.19. Nov. 11 1947 ms. Jan. Severe
(Date rec'd by registrar) deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 11 19 47 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 19 46 to Nov 11 19 47and that I last saw h..... alive on Nov 11 19 47

Immediate cause of death.....

arteriosclerosishypertension

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

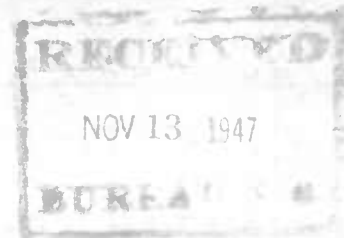
Address.....

Date signed..... Nov 11/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2528

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County... Prince Georges
 City or town... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 2 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... D. C. County...
 City or town... Washington,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 633 - M. Street, N. E.
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war...

3. (a) FULL NAME

MAUD MINGO

3. (b) Social Security Number

4. Sex Female	5. Color or race Colored	6. (a) Single, married, widowed, or divorced Single		
6. (b) Name of husband or wife				
6. (c) If alive, give age years				
7. Birth date of deceased (mo., day, yr.) October 14, 1920				
8. AGE: 27	Years 27	Months 0	Days 28	It less than one day hrs. min.
9. Birthplace... Washington, D. C. (Town, county, and state)				
10. Usual occupation... Day Work				
11. Industry or business				
FATHER	12. Name... Arthur Jones			
	13. Birthplace... Texas			
MOTHER	14. Maiden name... Daisy Mingo			
	15. Birthplace... Texas			

16. Informant

Address

17.

Removal Date thereof Nov. 12, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

Nov. 12, 1947 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... NOVEMBER 11, 1947, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 10 - 8 - 1947, to 11 - 11 - 1947
 and that I last saw him alive on 11 - 11 - 1947

Immediate cause of death

PULMONARY TUBERCULOSIS

DURATION

2 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinicane MD
 M. D. or other
 Address... Glen Dale MD Date signed 11/11/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 19 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10280

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

WILLIAM H. MOORE

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Lula M. Moore

7. Birth date of deceased (mo., day, yr.) March 4th, 1881 6.(c) If alive, give age _____ years

8. AGE: Years 66 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Upper Marlboro, Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farmer

12. Name Joseph Moore

13. Birthplace Maryland

14. Maiden name Mary Peacock

15. Birthplace Maryland

16. Informant Mrs. Zora M. Corley

Address Upper Marlboro, Md.

17. Burial Date thereof Dec. 2nd 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Switzland Md.

18. Funeral director Arthur E. Simmons

Address 2007- Nichols Ave. Ste. 1

19. Dec 1- 19 47 Edna F. Solimine
(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 19 47 at 12:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 11 19 44 to Nov 27 19 47

and that I last saw him alive on 11/27 19 47

Immediate cause of death Chr. myocar- DURATION

ditis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Alcmar M. D. or other _____

Address 2015 Nichols Date signed 4/29/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

LOCAL HEALTH DEPARTMENT FOR RECORD

FILE NO.

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

RECEIVED

DEC 9 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

190

10281

231

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Prince George's
 City or town Smithland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
Lineal Memorial Cemetery
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Smithland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4319 - Spring Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Montague Morris

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Louise Morris
 7. Birth date of deceased (mo., day, yr.) Sept 19, 1905
 6. (c) If alive, give age 45 years
 8. AGE: Years 42 Month 1 Days 1 If less than one day
42 hrs. 1 min.

9. Birthplace Virginia (town, county, and state)
 10. Usual occupation Electrician
 11. Industry or business U.S. Government
 12. Name John Morris
 13. Birthplace Virginia
 14. Maiden name Edith Ralph
 15. Birthplace West Virginia

16. Informant Mr. Louise Morris
 Address 4319 - Spring Street, Smithland
 17. (Burial, cremation, or removal. Which?) Burial Date thereof Nov 20 1947
 (month) (day) (year)

Cemetery or crematory Evergreen
 Location Blacksburg and
Flaschko Road
 18. Funeral director Flaschko Sons
 Address 144 Yellowville Rd

19. 11/19/47 1947 Amanda Dauncey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1947 at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
 and that I last saw h..... alive on 19

Immediate cause of death Exposure to cold
 DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results gives cause

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide accident Date of 11-16-47Where did injury occur? Smithland (City or town) Prince George's (County) Maryland (State)Injured at home, farm, industry, public place (where) Public houseMeans of injury Ray out in cold Injured while working23. SIGNATURE John Morris M. D. or otherAddress Smithland Date signed 11-17-47

RECEIVED

NOV 22 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10282

838

245

1. PLACE OF DEATH:

County Pro Gw Co
City or town University Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred: -
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Pro Gw Co
City or town University Park Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4315 Luckerman St
(If rural, give LOCATION)
2. (a) If veteran, name war -

3. (a) FULL NAME

Hedwig NABHOLZ

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Paul von Nabholz
6. (c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) 22 Sept 1867

8. AGE: Years 80 Months 1 Days 16 If less than one day - hrs. - min.

9. Birthplace Germany
(Town, county and state)
10. Usual occupation at home

11. Industry or business -

FATHER 12. Name Lerdinand Relpke
13. Birthplace Germany

MOTHER 14. Maiden name Marie von Eicensee
15. Birthplace Germany

16. Informant Paul Nabholz
Address University Park Md

17. Burial Burial Date thereof Nov 21, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Geo Washington
Location Hyattsville Md

18. Funeral director H. Gasche sons
Address Hyattsville Md

19. Nov 19 1947 James Servis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1947 at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCTOBER 47 to NOV 18 47 and that I last saw him ER alive on NOV 15 47

Immediate cause of death CEREBRAL EMBOLUS DURATION 20 yrs

Due to Arteriosclerosis

Due to -

Other conditions Hypertension 20 yrs

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. -

Autopsy results -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

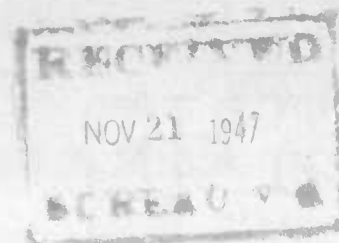
Means of injury - Injured at work? -

23. SIGNATURE Dr. Etienne Berwyn M. D. other
Address - Date signed Md

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



FILM No. G 114 FEB 3-1948 CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Prince George
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Two days, 16 hrs., & 20 min.
 Hospital, institution, or street address where death occurred:
Prince George's General Hospital
 How long in hospital or institution? 2 days, 16 hrs., & 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Cottage City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4010 Bladensburg Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

JOHN D. NELSON

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife La ishey May Nelson

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1886 6.(c) If alive, give age years

8. AGE: Years 61 Months 1 Days 16 If less than one day hrs. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business U. S. Gov't.

12. Name John Daniel Nelson

13. Birthplace Ind.

14. Maiden name Etta Smith

15. Birthplace Ind.

16. Informant Mr. Norman Nelson

4608 Decatur St., Edmonston, Md.

17. Burial Date thereof Nov. 17, 1947

(Burial, cremation, or removal, Which?) Fort Lincoln

Cemetery or crematory Colmar Manor, Md.

Location F. Gasch's Sons

18. Funeral director Hyattsville, Md.

Address 11/15 47 Amanda Downer

19. (Date rec'd by registrar) 3717-3812 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1947 19 47 at 12:05 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 19 47 to Nov 13 19 47

and that I last saw him alive on Nov 13 19 47

Immediate cause of death breast cancer DURATION 1939

Constricting Heart failure

Due to the phlebotomy

Spontaneous pneumothorax 1939

Due to 10 yrs. duration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

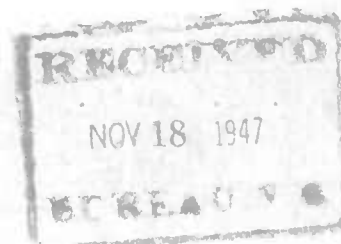
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George J. Hagazi M. D. or other

Address 3717-3812 Date signed 11/13/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

10284

Reg. Dist. No.

245

1. PLACE OF DEATH:

County..... Prince George
 City or town..... Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 13 days
 Hospital, institution, or street address where death occurred:
 Mother Jones Rest Home
 How long in hospital or institution?..... 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Prince George
 City or town..... Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1405 - 5th Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

4. Sex..... Female
 5. Color of race..... White
 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... George E. Nichols
 7. Birth date of deceased (mo., day, yr.)..... Oct 19 1861
 6.(c) If alive, give age..... years

8. AGE: Years..... 80 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Grand, Penn.
 (Town, county, and state)

10. Usual occupation..... none

11. Industry or business.....

12. Name.....

13. Birthplace..... Unknown

14. Maiden name.....

15. Birthplace.....

16. Informant..... Brother Jones Rest Home

Address..... Hyattsville Md

17. Burial.....

(Burial, cremation, or removal. Which?) Date thereof..... Nov 12th 1947
 (month) (day) (year)

Cemetery or crematory.....

Location..... Jackson Michigan

16. Funeral director..... Robert Mattingly

Address..... 131-11th St. S.E. Wash. D.C.

19. Nov 10 1947 James Seay

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 10 1947, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 1947, to Nov 10 1947, and that I last saw him alive on Nov 10 1947.

Immediate cause of death.....

DURATION

Hypertensive Pneumonia 2 days

Due to Cerebral Hemorrhage 11/6 + 14/5/47

Due to Gen Arteriosclerosis & Hypertension

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

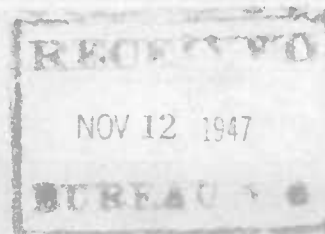
Means of injury..... Injured at work?

Address..... Mrs Wm Brannin & HT Moore

23. SIGNATURE..... M. D. registrar

28 Carroll Ave Takoma Park Md

Address..... Date signed..... 11/10/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County Prince Georges
City or town Brandywine, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Arthur William Pickeral

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Magie Ethel Pickeral 6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) April 1st 1885

8. AGE: Years 62 Months 7 Days 10 If less than one day..... hrs. min.

9. Birthplace Waldorf, Charles Co. Md
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

12. Name Peter Pickeral 13. Birthplace Waldorf, Md

14. Maiden name Rebecca King 15. Birthplace Waldorf, Md

16. Informant Magie E. Pickeral
Address Brandywine, Md

17. Burial Date thereof Nov. 13, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland Cemetery
Location near Waldorf, Md

18. Funeral director Hunt & Ryan
Address Waldorf, Md

19. Nov. 11, 47 F. H. Billingsley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 - 1947 8:54 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9th 1947 to Nov 10th 1947 and that I last saw him alive on Nov. 10th 1947

Immediate cause of death Tumor of Abdomen
Aneurysm of Aorta
Due to Arterio Sclerosis
Atherosclerosis
Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE John E. Bowers M.D.
M. D. or other

Address Brandywine, Md Date signed 11/11/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 13 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Baltimore
 City or town Halters Mill Rd 20777
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore
 City or town Halters Mill Rd
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 20777
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Annie Cecilia Pinkney
 4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Walter Pinkney

7. Birth date of deceased (mo., day, yr.) July 8 1885 8.(c) If alive, give age 58 years

8. AGE: Years 62 Months 4 Days 17 If less than one day hrs. min.

9. Birthplace T.B. Camm brook Md
 (Town, county, and state)

10. Usual occupation home duties

11. Industry or business same

12. Name Alfred Elavis

13. Birthplace Md.

14. Maiden name unknown

15. Birthplace Md.

16. Informant Walter Pinkney

Address 7777 Halters Mill Rd. Md

17. Burial Date thereof 11-28-1947
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Mt. Calvary Cemetery

Location upper Marlboro P.G. Md.

18. Funeral director Henry S. Washington & Sons

Address 467 W St. N.W. Wash. D.C.

19. 11-26 1947 Carrie Campbell
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1947 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1946 to Nov 25 1947

and that I last saw him alive on Nov 25 1947

Immediate cause of death cardiac decompensation

Due to chronic valvular heart disease

Due to none

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE 3 M Brady M.D.

Address 8 Cat P. Harrow Md Date signed Nov 25/47

RECEIVED

RECEIVED

RECEIVED
DEC 1 1947
RECEIVED

The Change of Cemetery on
Anne Pinkney from Mt. Carmel
Upper Marlboro. To Mt. Calvary Cemetery
Forrestville Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's General Hospital
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days and 8 hrs.
 Hospital, institution, or street address where death occurred:
Prince George's General Hospital
 How long in hospital or institution? 12 days and 8 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Mt. Rainier
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3306 Shepherd Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

CHARLES H. PRYOR

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Alice M. Pryor
 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 29, 1872

8. AGE: Years 75 Months 2 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Joseph H. Pryor

13. Birthplace Baltimore, Maryland

14. Maiden name Olivia Ann Cook

15. Birthplace Baltimore, Maryland

16. Informant Alice M. Pryor

Address 3306-Shepherd St. Mt. Rainier, Md.

17. Burial Date thereof Nov. 10, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine Cemetery

Location Baltimore, Maryland

18. Funeral director William J. Nalley

Address 3200-Rhode Island Ave. Mt. Rainier

19. Nov 9 19 47 Amanda H. Pryor
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1947 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 23 19 45, to Nov. 6 19 47
 and that I last saw him alive on Nov. 6, 1947

Immediate cause of death Acute Pulmonary Thrombosis - Rt. Lung DURATION 5 min.

Other conditions Acute Suppurative Pancreatitis 2 weeks
Chronic Hypertrophy Prostate 33 months
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles C. Hagage M.D. M.D. or other _____

Address Mt. Rainier, Md. Date signed Nov. 7, 1947

RECEIVED

NOV 13 1947

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10288

1570

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince GeorgeCity or town Glenbelt, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2- years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Glenbelt
(If outside city or town limits, write RURAL and give nearest town)Street No. 14-H. Ridge Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Richard Louis Radvazo

3. (b) Social Security Number

4. Sex

M.

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

none

7. Birth date of deceased (mo., day, yr.)

Sept. 23, 1942

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

5 years

.....hrs.min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

none

FATHER

12. Name

Henry Radvazo

13. Birthplace

New Hampshire

MOTHER

14. Maiden name

Rosetta Radvazo

15. Birthplace

New Hampshire

16. Informant

Mrs. Rosetta Radvazo

Address

14-H. Ridge Rd. Glenbelt Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

11/2
(month) (day) (year)

Cemetery or crematory

Concord Cemetery

Location

Concord, N.H.

18. Funeral director

W.H. Chambers Co.

Address

5801 Cleveland Ave. Riverdale Md.

19.

Nov 2
(Date rec'd by registrar)11/7 James Berry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 1, 1947, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1944, to October 30, 1947and that I last saw him alive on October 29, 1947

Immediate cause of death

Respiratory failure

DURATION

Due to

Increased intra-cranial pressure

Due to

Internal Hydrocephalus
(Congenital)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William Eiser

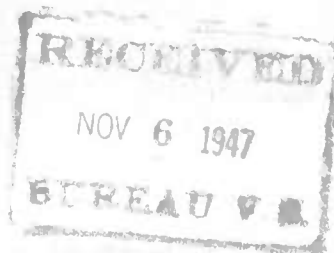
M. D. or other

Address

16 B Parkway GlenbeltDate signed 10/1/47

This death was discussed with Dr. Boyd - who
authorized removal of the remains of the deceased

W. C. B. (J)
(11/1/47)



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10289

Reg. Diat. No. 243

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 mos., 15 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 8 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9410 Balto. & Wash. Blvd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

DOROTHY MILDRED RAYBURN

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

October 23, 1916

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

313114

hrs.

min.

9. Birthplace

Princess, Kentucky
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

Henry Rayburn

13. Birthplace

Greenup, Kentucky

14. Maiden name

Flora Artis

15. Birthplace

Greenup, Kentucky

16. Informant

Deceased

Address

17.

Removal
(Burial, cremation, or removal. Which?)

Date thereof

11-28-47
(month) (day) (year)

Cemetery or crematory

to Hyattsville Md.

Location

18. Funeral director

F. Harsch & Son's

Address

Hyattsville Md.

19.

Nov 28, 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 27, 1947 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 11, 1947 to Nov 27, 1947
and that I last saw her alive on Nov 27, 1947

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 1/2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Pulmonary tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Finucane MD
M. D. or other

Address

Glenn Dale, Md.

Date signed

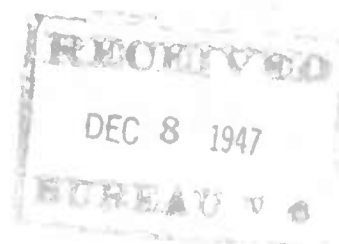
11/27/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10290

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's
City or town Chesley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 hrs. 15 min.
Hospital, institution, or street address where death occurred:
Pr. Geo. Gen'l. Hosp.
How long in hospital or institution? 9 hrs. 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Pr. Geo.
City or town Leah Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7003 - 7th.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Sampson, Mrs. Louisa

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband or wife George J. Sampson

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1883 6.(c) If alive, give age _____ years

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace md. (Town, county, and state)

10. Usual occupation H.W.

11. Industry or business

12. Name Charles Pflieger
13. Birthplace md.

14. Maiden name Mary V. King
15. Birthplace Va.

16. Informant Charles J. Sampson
Address 4513 Madison Ave. Riverdale, Md.

17. Burial Date thereof 11/25/47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Prophet Hill Cem.
Location Wash. D.C.

18. Funeral director W. X. Hartmann
Address 5432 Georgia Ave., N.W.

19. 11/22 19 47 Amos W. Wooten
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 19 47 at 10 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 19 47, to Nov. 22 19 47
and that I last saw him alive on Nov. 22 19 47

Immediate cause of death Cardiac accident DURATION 4 days

Due to Contracture with dehydration
+ anoxia 7 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Brannin M. D. or other
Capital Hqts, Md. Date signed 11/22/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 25 1947
BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *215*

1. PLACE OF DEATH:

County *Pro Geo Co*

City or town *Stattsville Md*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *4 months*

Hospital, institution, or street address where death occurred:
Mother Jones Rest Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State *2nd* County *Pro Geo*

City or town *Chesley Md.*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *1800 - 64 ave*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna Adelaide Sarch

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *widower*

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *June 9, 1869.* 6.(c) If alive, give age years

8. AGE: Years *78* Months Days If less than one day hrs. min.

9. Birthplace *Illinois*
(Town, county, and state)

10. Usual occupation *at home*

11. Industry or business

12. Name *unknown*

13. Birthplace *N.Y.*

14. Maiden name *Lydia Fox*

15. Birthplace *N.Y.*

10. Informant *Arthur Buck*

Address *Chesley Md.*

17. *Burial* Date thereof *Nov 24, 1947*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *East Harrisburg Cemetery*

Location *Harrisburg Pa.*

18. Funeral director *F. Busch's sons*

Address *Stattsville Md.*

19. *Nov 22* 19*47* James Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *11/19/47* at *9 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *10/2* 19*47* to *11/19/47* 19*47*.
and that I last saw him alive on *11/16/47* 19*47*.

Immediate cause of death

Corbular Spinaemia

Due to

Due to

Other conditions *Hypertension*

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

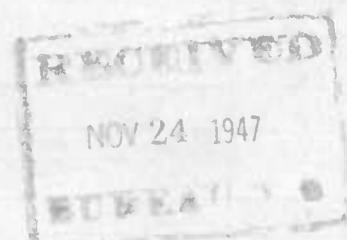
23. SIGNATURE *Howard Thomas MD*

28 Laurel Lane Phone Park Rd M. D. or other
Address Date signed *11/20/47*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23/

1. PLACE OF DEATH:

County Pr Geo
 City or town Bladensburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5-5 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Pr Geo Co
 City or town Bladensburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Kenilworth Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Katherine Seamberlich

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Charles F Seamberlich
 7. Birth date of deceased (mo., day, yr.) Jan 2, 1864 8. (c) If alive, give age — years
 8. AGE: Years 83 Months 9 Days 29 If less than one day
 9. Birthplace Germany
 (Town, county, and state)
 10. Usual occupation housewife

11. Industry or business

12. Name Charles F Heide
 13. Birthplace Germany
 14. Maiden name unknown
 15. Birthplace Germany
 16. Informant Mrs Julia Petty
 Address Bladensburg Md
 17. Burial Burial Date thereof Nov 3, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Evergreen
 Location Bladensburg Md
 18. Funeral director F. Busch, sons
 Address Hyattsville Md
 19. Nov 2 19 47 Amanda Downey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1, 1947 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947 to 11-1-47
 and that I last saw her alive on 10-28 19 47

Immediate cause of death Heart failure
arterio-sclerotic Heart
disease

Due to arterio-sclerosis

Other conditions Parkinson's disease
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dayton O Watkins Md M. D. or other
 Address 5306 Annapolis Rd Date signed 11-1-47

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NOV 5 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10293

1. PLACE OF DEATH:

County Prince George's

City or town Clinton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

Branch Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Clinton
(If outside city or town limits, write RURAL and give nearest town)Street No. Branch Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Carrie Sellers

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Andrew Sellers

7. Birth date of deceased (mo., day, yr.)

July 17, 1883

8. AGE:

64

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Philadelphia Pa.
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name

Lushman

13. Birthplace

Lushman

MOTHER

14. Maiden name

Lushman

15. Birthplace

Lushman

16. Informant

Louis Sellers

Address

Box 25, Route #1, Clinton, Md.
transportation
(Burial, cremation, or removal, which?) Date thereof Dec 2, 1947
(month) (day) (year)

Cemetery or crematory

Arlington

Location

South Carolina

18. Funeral director

F. Casch's sons

Address

Hyattsville Maryland

19.

12/2 47
(Date rec'd by registrar)

19

Amanda Douney
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 30, 1947, at 12:54 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on

19

Immediate cause of death

Acute pulmonary edema

Due to

Acute congestive heart failure

Due to

Cardiovascular renal disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

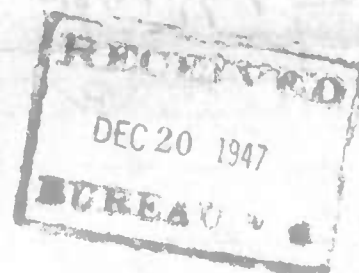
James D. J. [Signature]
M. D. or other
Address: [Signature] Date signed 11-30-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10294
231

1. PLACE OF DEATH:

County..... Prince George'sCity or town..... Cheverly
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 5 days

Hospital, institution, or street address where death occurred:

Prince George's General

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Massachusetts County.....City or town..... Stoughton
(If outside city or town limits, write RURAL and give nearest town)Street No..... 112 Charles
(If rural, give LOCATION)

2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

Gabriel Silva

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

April 30, 1929

8. AGE:

Years

Months

Days

If less than one day

18630

hrs.

min.

9. Birthplace.....

Massachusetts

(Town, county, and state)

10. Usual occupation.....

Exercise boy

11. Industry or business.....

Horse racing

FATHER

12. Name.....

John L. Silva

13. Birthplace.....

Madiera, Island Portugal

MOTHER

14. Maiden name.....

Mary Silva

15. Birthplace.....

Madiera Island, Portugal

16. Informant.....

Hospital records

Address.....

Cheverly, Md.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof.....

Nov. 22 1947

(month) (day) (year)

Cemetery or crematory.....

Location.....

Stoughton, Mass.

18. Funeral director.....

J. Arthur Walters

Address.....

505 Washington Blvd., Laurel, Maryland.

19.

11/1947Amanda Downey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 19 1947 at 12:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death.....

Respiratory paralysis

DURATION

Due to..... Ascending myelitisDue to..... Fracture and dislocation of the5th and 6th cervicle vertebrae withOther conditions..... compression of the cord

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of..... 11/14/47Where did injury occur?..... Laurel (City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... Laurel, Md.Means of injury..... Thrown from a horse Injured at work?

Deputy Medical Examiner.....

23. SIGNATURE..... James J. Ford M.D. or otherAddress..... Forestville, Md. Date signed..... 11/19/47

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 22 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

10295

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County... Prince George's

City or town... Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph Smiley

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife... Jessie Smiley

7. Birth date of deceased (mo., day, yr.) August 24, 1904

8. AGE: Years Months Days If less than one day

43

2

2

14

hrs.

min.

9. Birthplace... Pennsylvania
(Town, county, and state)

10. Usual occupation... Plumber

11. Industry or business

12. Name... Henry Smiley

13. Birthplace... Pennsylvania

14. Maiden name... Martha Cox

15. Birthplace... Pennsylvania

16. Informant... Hospital records

Address

17. Burial Date thereof Nov 13, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington Cemetery

Location... Va

18. Funeral director... F. Gasche's Sons

Address... Hyattsville Md.

19. 11/12 1947 Amanda Downey
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George's

City or town... Branchville
(If outside city or town limits, write RURAL and give nearest town)Street No... 9006 50th Place
(If rural, give LOCATION)

2. (a) If veteran, name war... World War # 2

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... November 10 1947 at 10:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Hemorrhage and shock

DURATION

Due to... Crushed chest

Fracture of the skull

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of 10/7/47

Where did injury occur? Berwyn P. O. (City or town) (County) (State) Md.

Injured at home, farm, industry, public place (where?) Route # 1

Means of injury... Pedestrian struck by an automobile

Deputy Medical Examiner

23. SIGNATURE... James S. Bond M.D. on behalf

Address... Forestville Md. Date signed 11-11-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 mos., 4 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 2 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 423 - 9th St., S. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MARVIN CLEO SMITH

3. (b) Social Security Number

579-10-5620

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife..... Olive Thayer (Deceased)

7. Birth date of deceased (mo., day, yr.)

Feb. 14, 1908

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

39

39

8

18

hrs.

min.

9. Birthplace.....

Fayette Co., Ohio
(Town, county, and state)

10. Usual occupation.....

Carpenter

11. Industry or business.....

FATHER
MOTHER

12. Name.....

John A. Smith

13. Birthplace.....

Fayette Co., Ohio

14. Maiden name.....

Stella V. Patton

15. Birthplace.....

Fayette Co., Ohio

16. Informant.....

Deceased

Address.....

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof.....

11-1-47
(month) (day) (year)

Cemetery or crematory.....

to Wash. DC

Location.....

18. Funeral director.....

Address.....

19. Nov. 1, 1947

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

NOVEMBER 1, 1947, at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death.....

PULMONARY TUBERCULOSIS

DURATION

5 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

Daniel Leo Pinicane M.D.

M. D. or other

Address.....

Glenn Dale, Md.

Date signed..... 11/1/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 19 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10297

245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Rivendale, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 hr. 20 min.

Hospital, institution, or street address where death occurred:

Engle's Deland Mem. Hosp.How long in hospital or institution? 4 hr. 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Blondale
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If rural, give LOCATION)2.(a) If veteran, name war na

3. (a) FULL NAME

William Marvin Smythe

3. (b) Social Security Number

not known

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Bertha Smythe6.(c) If alive, give age 39 years

7. Birth date of

deceased (mo., day, yr.)

Jan. 16, 1902

8. AGE:

Years

Months

Days

It less than one day

45108

hrs.

min.

9. Birthplace Friedrichsburg, Stafford Co., Va.
(Town, county, and state)10. Usual occupation Contractor11. Industry or business own.

MOTHER

FATHER

12. Name Edward Smythe13. Birthplace Stafford, Va.14. Maiden name Martha Witt15. Birthplace Virginia16. Informant Jack Smythe (son)Address Blondale, Md.17. Burial Date thereof 11-29-47
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Ht. Lincoln CemeteryLocation Washington, D.C.18. Funeral director W. W. Chambers, Co.Address 8801 Cleveland Ave.Rivendale, Md.19. Nov 26 1947 James Servey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1947 at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 15, 1946 to Nov. 23, 1947and that I last saw him alive on Nov. 23, 1947Immediate cause of death Cancer of lip & larynxPrimary & adenoidmetastasis to heartDue to metastasis to heartDue to metastasis to heartOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations Ca of lip & metastasisAutopsy results Ca of primary adenoid & metastasisPHYSICIAN: Please underline the cause to which death should be charged metastasis to heart

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury for autopsy - only23. SIGNATURE Cal. Jones U.S. Army (M.C.)Address Walter Reed Hosp. Date signed 11-25-47

RECEIVED

NOV 29 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1312

10298

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George's

City or town Forestville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

8370 Leona Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Forestville
(If outside city or town limits, write RURAL and give nearest town)Street No. 8370 Leona Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Charles William Sarrell Jr

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Myrtle Sarrell

6.(c) If alive, give age 40 years

7. Birth date of

deceased (mo., day, yr.) August 17, 1904

8. AGE:

Years

Months

Days

If less than one day

43

hrs.

min.

9. Birthplace Washington DC
(Town, county, and state)

10. Usual occupation Cab Driver

11. Industry or business

FATHER

12. Name

Charles William Sarrell

13. Birthplace

Washington D.C.

MOTHER

14. Maiden name

Margaret Kylie

15. Birthplace

Ireland

16. Informant

Myrtle Sarrell

Address

8370 Leona Street

17.

(Burial, cremation, or removal, Which?)

Date thereof

Nov. 11-1947
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Pr. Geo's Co. Md.

18. Funeral director

Thompson & Son, Inc. Co

Address

300 - 4th St. N. E.

19.

(Date rec'd by registrar)

19. 47

Edna F. Collins

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1947 at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Acute congestive heart failure
Due to Cardiovascular renal disease

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

James D. Fay

M. D. or other

Address

Forestville Md

Date signed 11-7-47

RECEIVED

NOV 17 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

838

10299

Reg. Dist. No.

245

1. PLACE OF DEATH: LELAND MEMORIAL HOSP
 County PRINCE GEORGES
 City or town RIVERDALE Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hours
 Hospital, institution, or street address where death occurred:
Riverdale Md. Leland Memorial Hospital
 How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County Prince George
 City or town Riverdale Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5305 - 50th Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Thomas J. Stacks

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Luna Catherine Stacks
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 28 1866
 8. AGE: Years 81 Months 4 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Patomac Md.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Farming
 12. Name Sarah Ann Booth
 13. Birthplace Bethesda
 14. Maiden name Joseph Edward Stacks
 15. Birthplace Bethesda

16. Informant daughter Mrs. Gonsell
 Address 5305 - 50th Ave Riverdale Md
 17. Removal Date thereof 11-19-47
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Bethesda Md.
 Location 7577 1st Ave on Belknap
 18. Funeral director Mr. Arthur J. Smith
 Address Bethesda, Md.
 19. Nov 19 1947 James Serry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1947 at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from live 1947 to Nov 1947
 and that I last saw him alive on Nov 18 1947

Immediate cause of death Cerebral Thrombosis DURATION 2 hrs
gastrointestinal hemorrhage 24 hrs
 Due to generalized arteriosclerosis 20 yrs
Cerebral, cardiac, peripheral 20 yrs
 Due to peripheral
 Other conditions Chronic, secondary 5 yrs
nutritional
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Benjamin S. Miller M. D. or other
3824-31st St. Riverdale Address _____ Date signed 11-19-47

RECEIVED

NOV 20 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10301

1. PLACE OF DEATH:

County Prince George

City or town Forestville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Forestville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Armstrong Lane
(If rural, give LOCATION)

2.(a) If veteran, name War

3. (a) FULL NAME

Philip J. Stuhnes

3. (b) Social Security Number

4. Sex

male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Annie

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

June 28, 1865

8. AGE:

Years

Months

Days

If less than one day

82

hrs.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER
FATHER

12. Name

Henry Stuhnes

13. Birthplace

Germany

14. Maiden name

Mary Elizabeth Miller

15. Birthplace

Washington D.C.

16. Informant

Philip Stuhnes

Address

5450 - Humphrey Drive Wash. D.C.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Nov 12, 1947
(month) (day) (year)

Cemetery or crematory

Greenwood Cemetery

Location

Washington D.C.

18. Funeral director

John D. Mattingly

Address

1315 11th St. N.E. Wash. D.C.

19.

Nov 10
(Date rec'd by registrar)

19

47

James Servey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 10 1947, to Nov 9 1947

and that I last saw him alive on Nov 9 1947

Immediate cause of death

Cardiac failure

DURATION

Due to

Due to

Other conditions

Carcinoma of liver

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Philip Stuhnes MD

M. D. or other

Address

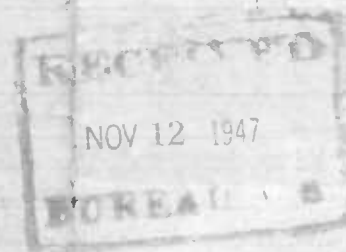
4313 - Melton

Date signed Nov 10 1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10300
Reg. Dist. No. 243.

1. PLACE OF DEATH:

County..... Prince Georges
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 19 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 month, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Ambassador Hotel, 11th & K. Sts., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Stultz, Henry John

3.(b) Social Security Number

717-12-6297

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Separated

6.(b) Name of husband or wife Marie Stultz

7. Birth date of deceased (mo., day, yr.) October 8, 1920 6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
27 27 1 18 hrs. min.

9. Birthplace..... Rockford, Illinois
(Town, county, and state)

10. Usual occupation..... Hotel Clerk, Roosevelt Hotel.

11. Industry or business - - -

FATHER 12. Name Henry Stultz
13. Birthplace Chicago, Illinois

MOTHER 14. Maiden name Gertrude Delaney
15. Birthplace Hollidaysburg, Pennsylvania

16. Informant Deceased
Address

17. Burial Date thereof Nov. 26, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Blair County
Location Hollidaysburg, Pa.

18. Funeral director J. H. Thomas Co.
Address 2901-14th St. N.W. D. C.

19. Nov. 26, 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1947 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/6 1947 to 11/26 1947 and that I last saw him alive on 11/26 1947.

Immediate cause of death Pulmonary Tuberculosis DURATION 5 years

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinneane MD
Address of Glenn Dale, Md. Date signed 11/26/47
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 8 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 6 months, 18 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 yr., 6 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... 625 - 2nd St., S. W., Washington, D. C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 625 - 2nd St., S. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

JOHN TATE

3. (b) Social Security Number

578-26-3594

4. Sex..... Male
 5. Color or race..... Colored
 6. (a) Single, married, widowed, or divorced..... Widowed
 6. (b) Name of husband or wife..... Elizabeth Thompson
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... September 25, 1891
 8. AGE: Years..... 56 Months..... 56 Days..... 1 If less than one day..... hrs. min.
14

9. Birthplace..... Richmond, Virginia
 (Town, county, and state)
 10. Usual occupation..... Laborer
 11. Industry or business.....
 12. Name..... Charles Tate
 13. Birthplace..... ? Virginia
 14. Maiden name..... Mary Washington
 15. Birthplace..... ? Virginia

16. Informant..... Deceased
 Address.....

17. removal Date thereof..... Nov. 8, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....
 Location..... Washington D.C.

18. Funeral director..... John T. Rhine Co.
 Address..... 3rd + Eye St. S.W.

19. Nov. 8, 47 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... NOVEMBER 8, 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 20, 1946 to Nov 8, 1947
 and that I last saw him alive on Nov. 8, 1947

Immediate cause of death..... PULMONARY TUBERCULOSIS
 DURATION..... 2 yrs 3 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

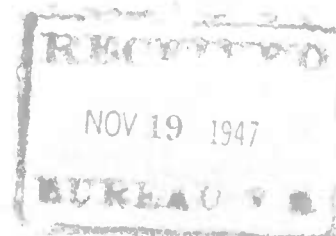
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Daniel Leo Pincus M.D.
 M. D. or other

Address..... Glenn Dale, Md. Date signed..... 11/8/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince GeorgeCity or town Christy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or other address where death occurred:

Prince George General Hospital

How long in hospital or institution?

5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ida Schubert Thieme

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Adolph Thieme

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 10 - 1863

8. AGE:

Years

Months

Days

If less than one day

84611

hrs.

min.

9. Birthplace

Walden
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

12. Name

John Schubert

13. Birthplace

Safony, Germany

14. Maiden name

Mary

15. Birthplace

Safony, Germany

18. Informant

Edman C. Thieme

Address

Mitchellville, P. Geo. Co., Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

11-24-47
(month) (day) (year)

Cemetery or crematory

W. Oak

Location

Mitchellville, Md.

18. Funeral director

Fitch Brothers

Address

Upper Marlboro, Md.

19.

(Date rec'd by registrar)

11/21/47Amanda Dauner

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 21 1947, at 7:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1947, to Nov 21 1947and that I last saw her alive on Nov 20 1947

Immediate cause of death

Constrictive Heart Failure

Due to

Hypertensive Cardiac Vascular Renal Disease

Due to

Compound Fracture Left Femur

Other conditions

Obesity

(Include pregnancy within 8 months of death)

Major findings of operations

none

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 11-12-47

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

homeMeans of injury Fell in bedroom

Injured at work?

23. SIGNATURE

James B. Tansler

Address

Upper Marlboro Md.Date signed 11-21-47

RECEIVED

CERTIFICATE OF DEATH

STATE OF NEW YORK

TO THE DEPARTMENT OF HEALTH

RECEIVED
NOV 22 1947
K-HEAD

ADOLF E. AM-1101

IN THE COUNTY OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10304
Reg. Dist. No. 231

1. PLACE OF DEATH:

County PRINCE GEORGECity or town CHEVERLY
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

PRINCE GEORGE COUNTY HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County PRINCE GEORGECity or town CAPITAL HEIGHTS
(If outside city or town limits, write RURAL and give nearest town)Street No. 822-58th AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

FRANK RONALD VENDEMIA

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

SEPT. 4, 1947

8. AGE:

Years

Months

Days

If less than one day

225

hrs.

min.

9. Birthplace

Prince George County Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

SAM VENDEMIA

13. Birthplace

MD.

14. Maiden name

BERTHA SHEAFER

15. Birthplace

MD.

16. Informant

SAM VENDEMIA

Address

822-58th AVE - CAPT. HTS. MD.17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

DEC 1 1947
(month) (day) (year)

Cemetery or crematory

WASH. NATIONAL

Location

SUITLAND MARYLAND

18. Funeral director

W. W. CHAMBERS CO

Address

517-11th ST. S.E.19. 11/29

(Date rec'd by registrar)

19. 47Amanda Doucay

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1947 at MD

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1, 1947 to November 19, 1947and that I last saw him alive on November 29, 1947

Immediate cause of death

1) Pneumonia Fibrosis
2) Bronchopneumonia

DURATION

3-4 weeks2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William Brainin

M. D. or

Address

Capital Hts, Md.

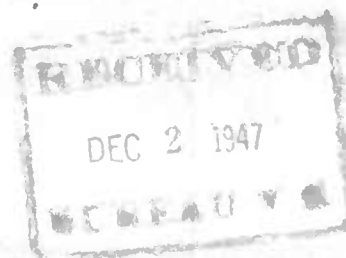
Date signed

11/29/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges County
 City or town Capitol Hights Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
 City or town Capitol Hights Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 503 65th Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret E. Vernon

3. (b) Social Security Number

578-12-1833

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Frank H. Vernon
 6. (c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) Dec. 7, 1904
 8. AGE: Years 42 Months 10 Days 25 If less than one day
hrs.min.

9. Birthplace Washington D. C.
 (Town, county, and state)
 10. Usual occupation Sales clerk
 11. Industry or business Dept. Store

12. Name Harry T. Mosner
 13. Birthplace Mass.
 14. Maiden name Mary A. Lowler
 15. Birthplace Washington D. C.

16. Informant Frank H. Vernon
 Address 503-65th Ave. Capitol Hgts Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 4, 1947
 (month) (day) (year)
 Cemetery or crematory Cedar Hill Cem.
 Location Suitland Md.

18. Funeral director Hay W. Wastler
 Address 301 E. Capitol St. Washington D. C.

19. For 1 1947 Amanda W. Wastler Registrar
 (Date rec'd by registrar) Carrie Campbell

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1947 at 9⁴⁵ A. M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 15, 1943 to November 1, 1947
 and that I last saw him alive on October 31, 1947.
 Immediate cause of death Coronary artery with infarction
 DURATION 3 years
 Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE William Brannin M. D. or other
 Address Capitol Heights Md. Date signed 11/1/47

RECEIVED
NOV 7 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a 10306 231
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Prince Georges
 City or town Mc Carthy
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
at well in yard
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED;

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Mc Carthy
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Josephine Louise Washington

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored married

6. (b) Name of husband or wife Charles Washington6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) 18858. AGE: Years 62 Months _____ Days _____ It less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Benjamin Allen13. Birthplace Maryland14. Maiden name Sarah Conlee15. Birthplace Maryland16. Informant Charles WashingtonAddress Lanham, Md.17. (Burial, cremation, or removal, Which?) Burial Date thereof Nov 21, 1947
(month) (day) (year)Cemetery or crematory woodmoor Catholic ChurchLocation woodmoor Md18. Funeral director St. Pasch's sonsAddress Bladensburg Md.19. 11/19 1947 Amanda Sounes
(Date rec'd by registrar) Registrar11/22/47 Mrs. Jack Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18, 1947 at 5405

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

Acute Corrigestive heart failureDue to cardiovascularrenal disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Amanda Sounes M. D. or other _____Address Theshall Md Date signed 11-19-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 224

1. PLACE OF DEATH:

County Prince George'sCity or town Clinton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? TransientHospital, institution, or street address where death occurred:
Thrift Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 5207-38th Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

John Brownee West

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Caroline West7. Birth date of deceased (mo., day, yr.) Feb 20, 18808. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation Machinist11. Industry or business Retired12. Name Elisha West13. Birthplace Pennsylvania14. Maiden name Elisha Gibson15. Birthplace Ireland16. Informant John D. West JrAddress Clinton, Md17. Burial Date thereof Nov 29, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. LincolnLocation Washington D.C.18. Funeral director F. Pasch's sonsAddress Hyattsville Md.19. 11/28 47 Amanda Deuney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1947, at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw h..... alive on.....19.....

Immediate cause of death Coronary occlusionDue to Cardiovascular renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

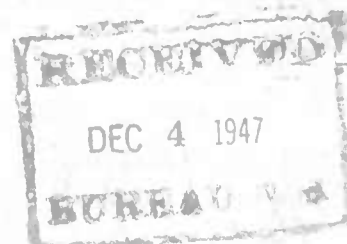
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Deputy Medical Examiner

Injured at work?

23. SIGNATURE James D. BoydAddress Hyattsville Md. Date signed 11-27-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *145*

1. PLACE OF DEATH:

County *Prince Georges*
City or town *Riverdale*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *4 years*
Hospital, institution, or street address where death occurred:
4404 Queensbury Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
State *Maryland* County *Prince Georges*
City or town *Riverdale*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *4404 Queensbury Rd.*
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Margaret White

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *William B White*

7. Birth date of deceased (mo., day, yr.) *June 6, 1862* 6. (c) If alive, give age years

8. AGE: Years *85* Months *5* Days It less than one day hrs. min.

9. Birthplace *Scotland*
(Town, county, and state)

10. Usual occupation *Pastry Cook*

11. Industry or business *Bakery*

12. Name *Mrs. Paul*

13. Birthplace *Scotland*

14. Maiden name *Margaret Browlee*

15. Birthplace *Scotland*

16. Informant *Mrs. Agnes Malin*

Address *4404 Queensbury Rd Riverdale Md*

17. Burial (Burial, cremation, or removal, Which?) Date thereof *Nov. 6, 1947*
(month) (day) (year)

Cemetery or crematory *Int. Lincoln Cemetery*

Location *Blacksburg Rd + District Line*

18. Funeral director *J. Arthur Walters*

Address *254 Canine St. NW Indian Park, D. C.*

19. *Nov. 6* 19*47* *Mrs. Jas. Severe*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 6* 19*47*, at *12:30* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *November 1943* to *Nov 6* 19*47*

and that I last saw him alive on *Nov 5* 19*47*

Immediate cause of death *Carcinoma of Stomach* DURATION *3 mo.*

Due to

Due to

Other conditions *Senility* *7 yrs.*

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Lawrence W Malin* M. D. or other

Address *Riverdale, Md.* Date signed *Nov 6, 1947*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 7 1947
BUREAU 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County... Prince George
City or town... Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 days
Hospital, institution, or street address where death occurred: Mother Jones Rest Home.
How long in hospital or institution? 80 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Md. County... Prince George
City or town... Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No... 8703 - 50 R PL
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Edward H. Wilcofen

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 27, 1882

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

65 64

9

28

hrs.

min.

9. Birthplace

Md
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

18.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 15, 1947, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 5, 1947, to Nov 15, 1947

and that I last saw him alive on

Nov 10, 1947

Immediate cause of death

DURATION

Can. Dig. Myocardial Infarction 3 months

Due to

Grossly hypertrophied heart with

Due to

Coronary atherosclerosis 5 yrs

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

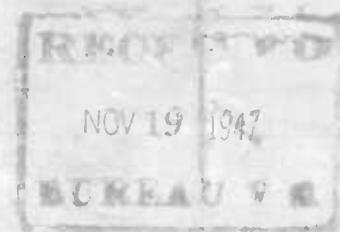
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

28 Carroll Ave. Takoma Park, Md. M.D. or other
Address... Date signed 11/15/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Pro Geo CoCity or town Cherry md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 minutesHospital, institution, or street address where death occurred:
Cherry md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Pro Geo CoCity or town Hyattsville md
(If outside city or town limits, write RURAL and give nearest town)Street No. 4309 Hamilton St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Francis Wolf

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary Wolf

7. Birth date of deceased (mo., day, yr.)

Mar 29, 18766.(c) If alive, give age 70 years

8. AGE:

Years

Months

Days

If less than one day

7179

hrs.

min.

9. Birthplace

Pa
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

U.S. Treasury Dept.

12. Name

John Wolf

13. Birthplace

Phila Pa

14. Maiden name

Ann Murphy

15. Birthplace

Phila Pa

16. Informant

John F Wolf

Address

Hyattsville md

17. Burial (Burial, cremation, or removal, Which?)

Date thereof

Nov 11, 1947

Cemetery or crematory

Ft Lincoln

Location

Washington D.C.

18. Funeral director

F. Busch's sons

Address

Hyattsville md

19.

Nov 9 47
(Date rec'd by registrar)

19.

Amanda Downay
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8, 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2, 1940 to Nov 8, 1947and that I last saw him alive on Nov 8, 1947

Immediate cause of death

Coronary Thrombosis

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. F. Wolf
Address Hyattsville md Date signed 11-847

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NOV 13 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. *ML*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince George'sCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D. C. County Washington D. C.City or town 309 Md Ave N E
(If outside city or town limits, write RURAL and give nearest town)Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Jefferson Woodyard

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Ann Woodyard

7. Birth date of deceased (mo., day, yr.)

May 2, 18986.(c) If alive, give age 45? years

8. AGE:

49

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Arlington virginia
(Town, county, and state)

10. Usual occupation

chauffer

11. Industry or business

Capital Sightseeing Co

FATHER

12. Name

Preylow E. Woodyard

13. Birthplace

virginia

MOTHER

14. Maiden name

Lucy Swain

15. Birthplace

virginia

16. Informant

Harry L. Woodyard

Address

2616 Key Bl'vd Arlington Va

17.

Removal

(Burial, cremation, or removal. Which?)

Date thereof Nov. 11, 1947
(month) (day) (year)

Cemetery or crematory

Ives Funeral Home

Location

Charendon Virginia

18. Funeral director

F. Gasch's Sons

Address

Hyattsville Maryland

19.

Nov. 11, 1947
(Date rec'd by registrar)Mrs. Jas. Severe
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1947 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death Hemorrhage and shock DURATIONDue to Crushed chestfracture of right arm

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11/11/Where did injury occur? Branchville P. G. Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Route #1 ionMeans of injury Passenger in car that was in a collision

Deputy Medical Examiner

23. SIGNATURE James H. Severe M. D. or otherAddress Forestville, Md. Date signed 11/11/47

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NOV 13 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10311

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges
City or town Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 1 month, 30 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 1 month, 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1962 2nd St., N. W.
(If rural, give LOCATION)
2.(a) Is veteran, name war

3.(a) FULL NAME

CAROL ANN WRIGHT

3.(b) Social Security Number

4. Sex Female
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife - - -
7. Birth date of deceased (mo., day, yr.) September 19, 1945
8. AGE: Years 2 Months 1 Days 28 It less than one day - hrs. - min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation - -
11. Industry or business - -
12. Name Ralph Wright
13. Birthplace Washington, D. C.
14. Maiden name Carolyn Evans
15. Birthplace Washington, D. C.

16. Informant Mrs. Carolyn Wright (mother)
Address 1962 2nd St., N. W.
17. Removal Date thereof Nov. 17, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory to Washington, D.C.
Location Robert & McQuire
18. Funeral director 1820 - 9th St. N. W.
Address Nov. 17, 1947
19. Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16th 19 47 at 10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16th 19 46 to Nov. 16th 19 47
and that I last saw him alive on Nov. 16th 19 47
Immediate cause of death Pulmonary Tuberculosis
(Tuberculosis)

DURATION 1 yr 3 mos
Due to - - -
Due to - - -
Other conditions - - -
(Include pregnancy within 3 months of death)

Major findings of operations - - - Date of op. - - -
Autopsy results - - -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

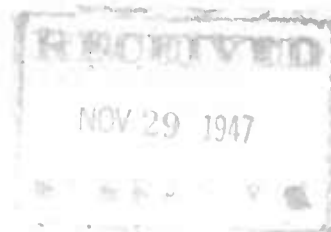
22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide - - - Date of - - -
Where did injury occur? - - - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) - - -
Means of injury - - - injured at work? - - -

23. SIGNATURE Daniel Leo Pinckney MD
M. D. or other - - -
Address Edna Dale, Md. Date signed 11/16/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

10312

1. PLACE OF DEATH:

County..... Prince George
 City or town..... Boulevard Heights
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... An. Geo.
 City or town..... Boulevard Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1802 - Southern Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

VELMAA. Zielie

3. (b) Social Security Number

4. Sex..... Female
 5. Color or race..... white
 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... August 21st. 1906
 8. AGE: Years..... 41 Months..... 3 Days..... 7 If less than one day..... hrs. min.

9. Birthplace..... Wisconsin
 (Town, county, and state)
 10. Usual occupation..... U.S. Govt. clerk
 11. Industry or business.....
 12. Name..... Chas. Zielie
 13. Birthplace..... Wisconsin
 14. Maiden name..... Johanna Brudguid
 15. Birthplace..... Norway

16. Informant..... Mrs. Beverley Burkett
 Address..... 4510 - 3rd. St. S.E.

17. Burial..... November 2. 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Cedar Hill
 Location..... Suitland, Md.

18. Funeral director..... Wm. Lee's Sons Co
 Address..... 300 - 4th. St. N.E. Wash. D.C.

19. Nov 30 1947 Carrie G. Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 28th. 1947 at 4-10 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1945 to Nov 28 1947
 and that I last saw him alive on Nov 28 1947

Immediate cause of death..... Carcinoma of stomach
 DURATION..... 2 yrs
 Due to..... metastasis

Due to.....
 Other conditions..... metastasis

(Include pregnancy within 3 months of death)
 Major findings of operations..... Carcinoma
 Date of op..... 1946

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
347 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Robert B Bacon M. D. or other
 Address..... Baerlyton Hotel Date signed..... 11/29/47

REMOVED
DEC 2 1947
BUREAU